Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) April :05 PM Physician Fulton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Prescott Court Harre De Grace 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Maryland **Funeral** Months Days Hours 1 M 2 □ F ept. 26, 1972 36 Yrs. 215-80-0670 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanines must be notified at 1 Yes 2 No Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States Taylor 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black <u>á</u> 3 Widowed 4 Divorced Be Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Baltimere Elementary/Secondary (0-12) College (1-4or 5+) Animal Caretaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vivian Sorrell Lee John ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vivian Fulton-Burston/Mother Baltimore, Maryland 21237 11 Days End Court Pages 1 and 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland permit. Page Department of Important: If any injury or once. Arbutus Memorial Park 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Calvin L. Williams Funeral Service, P. A 270 Fredhilton Pass Baltimore, Mary 21. Signature of Funeral Service Licensee Baltimore, Maryland 21229 Z. 09 Approximate Interval Between Onset and Death 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OSTPOSAYCOM **Physician** NOTO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) physician for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. a I I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate ! 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) -ELDWAN MD 111 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Hav 1/2001

09-03102 Kamari Fudge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2009 14002

		For State	Certificate		Reg. No.	3. Time of Death
hysiciar?		Decedent's Name (First, Midd	le,Last)	I .	Date of Death Month Day Ye	
Examin		Kamari	Fudge		pril 18, 2009	
	4	a. Facility Name (if not institution	on, give street and number)	4b. City, Town, or Location of Death	4c. County	of Death
		Johns Hopkins Hospi		Baltimore	N	[A
Euparal	5	Social Security Number	6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24Hrs. 8	. Date of Birth (MM/DD/YYY	
Funeral Director	ľ			Months Days Hours Min.	F-12-2008	
Director	ó	12-83-8746	1 M 2 F	Yrs. 8	0 10 000	, , , , , , ,
	_	sual Residence of Decedent	10c. City, Town or	Location		10d. Inside City Limits
a an	1	Da. State 10b. County	1			1 Yes 2 No
and sho	5	Md NI	A Balti	MOYE	10g. Citizen of V	What Country?
daryland 28a-f show any d at once.	5 1	0e. Street and Number	1 4 4 .	10f. Zip Code	11	2 1
the N	히	1285 Pen	fland Drive	21234	4	2,4
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Ex-miner must be notified at once	Funeral Director	1. Mantal Status		 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri 		ce - American Indian, Black, nite, etc.
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i. or		3 Widowed 4 D	ivorced If Yes, Give Yeer	1 Yes 2 No specify:	Specify	Black
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36 Illian	亂	Λ		NA		NA
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medic	Be	L E		Irinee	Flint	
21215-003 ould be filed within Mental Hygiene, marked other ti		19a. Informant's Name/Relation	nship (Type, Print) 19b.	Mailing Address (Street and Number or Ru	ral Route Number, City or T	
MD 2 d 2 shoulth and I m 27 is n	-	Towns El	nt-Carr mother 2	285 Pentland Dr	in Balto A	W. 21234
alth	-	20a. Method of Disposition	20b. Place of	Disposition (reality of someter)	Date 20c. Location	on - City or Town, State
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Pag ment tant:			Specify: Lorra:	120 Name and Address of Facility	Coop pac	Service P.A.
Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Funeral Servi	ce Licensee	20 Name and Address of Facility Q	To the	1 9 12 17
E.E.O.B.	_	Carloth	or complications that caused the death. Do not	t enter the mode of dving, such as cardiac or	respiratory arrest, shock, or	heart Approximate Interval
sician		23a. Part I. Enter the disease, failure. List only one cau	se on each line.			Between Onset and Death
	- 1	Immediate Cause (Final disea		ed death in infancy		
Examinor	- {	or condition resulting in death) Due to (or as a consequence of):			i l
		Sequentially list conditions,	b. Due to (or as a consequence of):			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death April 1 28 2009 4c. County of Death 4b. City, Town, or Location of Death Baltimore Middle River 8. Date of Birth March Day, Year), 1925 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Hours Min. M☐M 2☐F 84 10c. City, Town or Location 10b. County

1 - State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:00a M Anthony P. Fazio /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Chesapeake House Birthplace (State or Foreign
 Country) Social Security Number **Funeral** MD220-14-7460 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 28a-f show Middle River MD Baltimore 1 ☐ Yes 2 ☐ XNo permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Marked Examiner must be notified. Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21220 13132 Rivervan Avenue Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ∐ Yes 2 ∐XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Joseph A. Bank Co. Tailor 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Omodei Dominic A. Fazio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13132 Rivervan Avenue Baltimore MD 21220 Roseann Fazio /wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State PArkwood Cemetery 5/1/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service Licensee Balto. Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line/ not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bloods of light) that initiated events resulting in death) Last Due to quende of Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Tilnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 2 Ne 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

> State Registrar

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of de Hyman Akkad 7600

6 1 7889

AKKa

Dr. #411

ati (Item 23a) (Type, Print)

Osler

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:52 PM 26, 2009 April Bessie G. Fuhrmaneck /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 1 F 7/30/22 Maryland **Director** 86 214-16-8834 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1. Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21229 3559 Benzinger Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2. No 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Specify 3 Widowed 4 Divorced White Hygiene. other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Montgomery Ward s 1 and 2 should be filed with Health and Mental Hygier item 27 is marked other thother traumatic event, INS Fitting Room Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Forelifer Richard Porch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3559 Benzinger Rd. Baltimore, Maryland 21229 Francis E. Fuhrmaneck / Husband Pages 1 anent of Heart: If item 2 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Baltimore, Maryland Loudon Park Cemetery 4/30/09 22. Name and Address of Facility 21. Signature of Funeral Service Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. Lie implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to jor as a conse juence of : Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the nding p IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Month Year for 5 Other (specify) 4 Pregnant at time of death Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Records, Fohrmaneck 2 O 3 Probably 4 Unknown 1 □ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Ves 2 De No 2 🗆 No certificate 1 ☐ Yes 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be 2 (No Other: 4 Nursing Home 5 Residence tos hele Hospital: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification; To this After th funeral 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending I hin 24 hours after death. Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 1 > ertifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the deadle, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Month, Day,

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (/

4/26/09

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Externing must be notified at another. Baltimore, Maryland 21215-0036

Physic /Med Exami

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit +

Division of Vital Records, P.O. Box 68760,

Physicia Medic/		George Fodel	Ap	April 28, 2009 10:30P.M									
Examin		4a. Facility Name (If not institution, give street and number) 5905 Fairwood Avenue	4b. City, Town, or Location of Death Baltimore City	4c. County of De	ath								
uneral irector		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Davs Hours Min.	(Month, Day, Year)	irthplace (State or Foreign Country) nnsylvania								
WO III	ľ	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits								
a-f sh	ctor	Md. Balti	lmore City		¥∏Yes 2∏No								
or 28	Jire.	10e. Street and Number	10f. Zip Code	10g. Citizen of What (Country?								
23a	ral	5905 Fairwood Avenue	21206	U.S.A.									
tems er m	Funeral Director	Armed Forces?	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 		nerican Indian, nite, etc.								
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: W	hite								
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is ma		, , , , , , , , , , , , , , , , , , , ,	oute Number, City or Town, State										
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or of			rematory or other place)										
Injury		4 □Donation 5 □Other (Specify) St. Stat 21. Signature of Funeral Service Licensee	nislaus Cem 5-2-20		e,Maryland								
any			^{22. Name and} Address of Facility Kaczo 201 Dundalk Avenu	rowski funer La Baltimora	al Home, PA								
		23a. Part 1. Enter the disease, it complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between								
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edical		esulting in death) a. Due to (or as a consequence of):											
miner	L	Sequentially list conditions, b.	cmphysema	20 yea									
ısit	Examiner	Sequentially list conditions, if any leading to him ordinary cause. Enter Underlying Cause (Disease or injury	Thetautive Sleep	Repres	10 years								
n and al-tra	Exar	that initiated events resulting in death) Last c	7 7 7 7 7		7071								
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attending physician and for use as the burial-transit	sician/Medical		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month	delivery Day Year								
by the	Phys	9 Unknown											
After this certificate has been signed by funeral director, page 2 should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 █	e to the cause of death? Probably 4 🗆 Unknown								
peen	Completed	Hyperlipidemia											
ge 2 s	Idm	Dementia		24a. Was an autopsy performed? 24b. Were prior death	autopsy findings available to completion of cause of i?								
tificate or, pa		リピートして	26. Place of Death (C	1 ☐ Yes 2 🗷 No	es 2□No								
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I Directo	28a. Date of Injury M 28b. Time of Injury at Work? 1												
To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de and magner stated.	eath occurred at the time, date and place, and r investigation, in my opinion, death occurred	due to the cause(s) and manne at the time, date and place, and o	r as stated. due to the cause(s)								
To th	ğ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo									
		1 dhas	D 55846	April 29	, 2009								
+1		30. Name and address of person who completed cause of death (Item 23a) (Type											
V		Dr. Jason E. Goodman, M. D. 7602 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Belair Road Balt	imore, Md. 2	1236								
Sta Registr	A fact to												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:08 PM Goodson 2009 **Physician** April James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5 Social Security Number Day, Year) **Funeral** 1 **№** M 2 □ F South Carelina Aug. 247-28-9692 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Baltimore Directo Mary land 10f. Zip-Code Citizen of What Country? 10e. Street and Number Asquith Street United States 21218 items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 🖫 No Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction marked other than abover 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othr any injury or other traumatic event, once. Be Beasley Rexia Goodson Kobert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2318 Asquith Street Baltimore, MD. 21218 Michael George - Grandson altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mari Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 2. Name and Address of Facility and Funeral Service, P. A 270 Frednitton Pass Baltimore, Maryland 21229 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACZHEIMEVZ'S Complication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** porton Sie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed DEONPRU burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: asn 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Tetal death 3 - Ectopic pregnancy Month 4 Pregnant at time of death
Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed s certificate has b director, page 2 2 No Yes 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 KER/Outpatient 3 DOA 1 \square Inpatient ၉ 28a. Date of Injury (Month, Day Y 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: After completely filled in by the fune 5 Pending investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 Could not be determined 3 ☐ Suicide 4 Homicide

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

April 29, 2009 D0035468

29d. Date signed (Month, Day, Year)

ANG RACE

WO

62. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

State Registrar 29a. Certifier

29b. Signature

(check only one)

d title of certifier

31. Date filed (Month, Day, Year) MAY 0 1 2009

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Jarner 2009 **Physician** 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** timore Baltimore Care ulre TUYE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 17, 19 Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 M 2 V F Maryland 247(0 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28e-1 show 10c. City, Town or Location 10b. County 10a. State rthan "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No MD Baltimorcum Baltimort Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA Atho 21229 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces

1 Yes 2 No
If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WHITE Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith UNK George Bradley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Topaz Court Apt 1C Rosedale, Maryland 21237 Christina Augustine, Daughter or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Baltimore, Maryland 05/01/09 Metro Crematory Inc. 21. Signature of Funeral Service Licensee

Thomas Gregor Cremation Statety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of sping, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 000 **Physician** 0 disease or condition resulting in death) /Medical Due * or as a consequence of) Examiner Tre tes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed 2 2 No certificate 26. Place of Death (Check only one) ours after death.

naral Director: After this certific filled in by the funeral director. To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 V vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Hospitel or Attending 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a To the Funaral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier motor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dolphi

State Registrar 501

MACEM 32. Registrar's Si Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day B. EVIVO Month RIL **Physician** 5:00F Joseph Peter Gutkoska, Ph.D. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Baltimore OWSON 8. Date of Birth (Month, Day, Year) March 23,1928 9. Birthplace (State or Foreign Country) Baltinore, MD. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1X M 2□ F 81 220-18-3847 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Towson Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21286 1311 Milldam Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐No KOYCall 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates:Conflict 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Towson University College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk ment of Health and Mental H ant: If Item 27 is marked ott Be Beatrice Taluto George Gutkoska traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 21074 2400 Fairway Oaks Court Hampstead, MD. (Son) Mr. Kenneth G. Gutkoska If Item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel April 30 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Forest Hill, Maryland Important: I any injury o once. 2009 Department 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Prin. Errer the disease, ir complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the ck, of he if failure. Use only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 | Unknown þ 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown SEVERE CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has page 2 autopsy certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier klou, Mas D0017695 10_{λ_I} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND 21204 7601 ABDALLAH HELOU M. D 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 0 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician Fdward** Gillespie 4-23-2009 9:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1624 Forest Hill Avenue Baltimore 7. Age (In yrs. last birthday) 73 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jul. 22, 5. Social Security Number 6. Sex 1 X M 2 □ F Birthplace (State or Foreign Country) Days Hours Maryland 1935 220-30-4335 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ¥Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1624 Forest Hill Avenue 21230 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XYes 2 No 1954-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ Xyo If Yes, Give Year or Dates: Specify: White 1956 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distributor Baltimore Sun Papers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Patrick Gillespie Agnes Devaney 19a. Informant's Name/Relationship (Type. Print)
Edward Gillespie - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Forest Hill Ave., Baltimore, MD 21230 Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State b. Place of disposition (Name of Cemetery crematory of other place) 20c. Location - City or Town, State Date 5 ☐ Other (Specify) 4-30-2009 Odenton, Maryland Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Humaral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Salie la Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Vear 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

Physician /Medical Examiner Examine signed by the attending physician Physician/Medical as the detached 2 Completed has Be

Vital Records, P.O. Box 68760

Funeral

Director

ral", or items 23a or 28a-f st Examiner must be notified

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permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmast.

with the Maryland

Baltimore, Maryland 21215-0036

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

00052255

29c. License number

04-29-2008(2009)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

83: Chesafeake Dr Cambridge, MD 21613 31. Date filed (Month, Day, Year)

State Registrar

Medical

To the Hospital within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:15 PM April 2009 Margaret J. Gibbons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7795 Penninsula Expwy #312 Baltimore Dundalk
If Under 1 Year 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 26, 7. Age (In yrs. last birthday) **Funeral** 1930 Months Days Hours Min 1 □ M 2 🗓 F Director 212=26-0343 78 Aug Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2√ ☐ No Baltimore Dundalk MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7795 Penninsula Expwy #312 21222 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ Be Completed by 1 ☐ Yes 2 No Specify: White 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental I and the sunt: If item 27 is marked of Daniel Parker Gracey Violet Gladys Price ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 g Department of Health a Important: If item 27 is any Injury or other trau once. 8175 Del Haven Road Dundalk, MD 21222 Harri Mullenax/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ROITald 5. Wade/ 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. anter the disease or combinetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** *lears* Cance /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ✓ Probably 4 ☐ Unknown 1 ☐ Yes 2 🗌 No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 \square No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Daje signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eesel 2112 Dundal K

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		of Death	iu ivierita		9. No. 200	19 1401
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		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o		Death	4c. County of Death Montgomery	1
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arylan 8a-f sl atono	양	MD Montgomery Tak 10e. Street and Number	oma Pa	10f. Zip Code		10	g. Citizen of What Cou	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23n or 28n-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	6904 Cherry Avenue		20912			USA	
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212 212 Ments Mark	10 B	George Gittens 19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Stre			ber, City or Town, State	e, Zip Code)
MD 2 sho 27 is	7	Beverly Brown/ex-wife	2801	E 120th	Ave. A	pt. E201 7	Thornton, C	0 80233
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner must.				sposition (Name of coor other place)	emetery,	Date	20c. Location - City or	Town, State
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Physician /Medical		23. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.			g, such as card	liac or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and
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876 rtificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of print in the past 12 months?	regnancy 2	Fetal death 3	Ectopic pr	regnancy	23d. Date of deliver Month	y Day Year
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 6 Could not be determined (Specify)	t home, farm,	street, factory, office	building, etc.	28f, Location (\$ or Town, S		ural Route Number, City
the the	Medical C	29a, Certifier (Check only one) Certifying Physician: To the best of my knowl one) Wedical Examiner: On the basis of examination and manner stated.						
To with	Σ	29b. Signature and title of certifier		29c. Licer	nse number	· · · · · · · · · · · · · · · · · · ·	29d. Date signed (Mo	onth, Day, Year)
		O-rollin		O.C	.M.E.		April 7, 2009	
		30. Name and address of person who completed cause of death (It Donna M. Vincenti, MD Assistant Medical Ex		111 Penn Stree	t, Baltimore	e, MD 21201		
	~~	31. Date filed (Month, Day, Year) 32 Kegistrar's Sign	nature					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#18perFH 6891 5/1/09 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 27, Da 2009 Year 11:00P M **Physician** GIVNER ALLAN /Medical 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 4a. Facility Name (If not institution, give street and number) Examiner PIKESVILLE EMERITUS OF PIKESVILLE 8. Date of Birth MAY 8, 1910 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. MARY LAND **X** M 2□ F 98 215-07-3502 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be notified at any injury or other traumatic event, the Mexical Examiner must be notified at once. 1 ☐Yes 2X No Director BALTIMORE PHOENIX MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21131 2 WINDEMERE PARKWAY Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2√√No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MORTGAGE LENDER OWNER 18. Mother's Name (First, Middle, Maiden Surname) Hettleman 17. Father's Name (First, Middle, Last) Be SARAH GIVNER MOSES ပ္ 19b. Mailing Address (Street and Number or Fyral Route Number, City of Town, State Zin Code) 2 WINDEMERE PARKWAY PHOENIX, MARYLAND 21131 19a. Informant's Name/Relationship (Type. Print)
LARRY GIVNER/SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2009 | HYDES, MARYLAND ST. JOHNS CATHOLIC 21. Signatur of Juneral Service License 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. B900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on or hine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementig **Physician** Vasculas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760,∑ Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐Yes 2 ☐ No 1 □ Yes 2 🖳 📉 🗸 🗎 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mether (Specify) ASS 15 THE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Living 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: #
oletely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hos within 24 ho To the Functional (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 28, 2009 Naren L. Balett MID D58676

10

State Registrar Karen L. Babitt, M.D. Yoon ad ourt Road, 54/te 30/ 31. Date filed (Month, Day, Year) 32. Registrate Signature MAY 0 1 2009 Senson S. January S. January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltmore, MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of Maryland / Department of Health and Certificate of Death							nd Mental Hygiene Reg. No. 2000 11.013			
	_		Registrar 1. Decedent's Name (First, Middle, Last)				unca	OI L	Jean	2	. Date of Dea	ıth (UU 3	3. Time of Death
	Physicia		Joseph R. Hergan							l A	Month April 2	27, Day	009 Year	10:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and numbe	r)		4b. City	Town, or	Location of [Death		4c. Cd	ounty of Death	
3			437 Sudbury Road					nthic		Tura La	D . (D)		ne Arui	
	Funeral		5. Social Security Number 6. Sex 191–28–0472	M 2□ F 7. A	.ge (In yrs. I 74	last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hours	Min. 8	Date of Birth (Month, Day 9/29/	n Year) 1934	Wes	nplace (State or Foreign untry) t Wyoming, PA
	Director		Usual Residence of Decedent											
	rylane show	_	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	Director	MD Anne Arun	del	Lin	thicum		p Code				10a. Citize	n of What Co	
	with t		10e. Street and Number 437 Sudbury Road						-2044			US.		
	death	Funeral		12. Was Deceder Armed Forces	t Ever in U.	S. 13. V	Nas Dece	edent of H		n? (Speci	ify Yes or No-	14	. Race - Ame Black, White	
92	after or ite		1 Never Married 21 Married	112 Yes 2] No		il⊟Yes		Specify:	i dello i ii	ouri, o.c.,	s	pecify: Wh	
21215-0036	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates	:	16a. Deced	dent's Us	ual Occup	ation				of Business/	
5	in 72 n "nat	plet	(Specify only highest grade	completed)	(5.1)	(Give	kind of w	ork done o use retired	during most o	of working	,			
212	d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4o	J+)	L	ingu	ist				N.S		
Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)								First, Middle, ablons!		ırname)	
r <u>yla</u>	d Mer narke	입	Joseph Andrew He 19a. Informant's Name/Relationship (Ty			10h Mailir	a Addres	e /Street					Town, State, 2	Zip Code)
M	id 2 sl Ith an 27 is r traur		Theresa Hergan /								hicum,			,
Ē,	s 1 ar		20a. Method of Disposition		20b. P	Place of Dispo				/1/20			ation - City or	Town, State
<u>E</u>	Page ment c ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	e I	Vetera	n-Cr	owns	ville				nsvill	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner mant be recitied at once.		21. Signat e of Funeral Scryin License		220) 22 S	. Name : ervi	ces	ss of Facility (Sing Ave	leton SW, Gl	Funer en Bu	al and	Cremation MD 21061
ı.			23a. Fart 1. Enter the disease, or complishock, or heart failure. List only or	cations that caus	ed the deat	h. Do not ent	er the mo	de of dyir	ng, such as ca	ardiac or	respiratory a	rrest,		Approximate Interval Between
9	Physician	e i	Immediate Cause (Final disease or condition	m	eta	stati	ri	Blo	dde	N C	ance	1		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):								> 1400
		ē	Sequentially list conditions,	Due to (or a	as a conseq	uence of):								
	cuted nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2.										
, 0	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								
8760,	cate b physic the bi	dical		1										
9 x	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b, Was decedent pregnant	3c. If yes, outcor								23	3d. Date of de	livery
. Box	death e atte	iciar	in the past 12 months?	1 Live birtl	t at time of o		⊒ Ectopic ⊒ Other (pregnand specify) _	у				Month	Day Year
P.O.	at the 1 by th stache	hys	9 Unknown	9 Unknow					one in Book I		220 Did t	obacca us	o contribute to	the cause of death?
S,	ires that the de signed by the a	ρ	Part II. Other significant conditions co	ntributing to death	but not res	uiting in the u	naeriying	cause giv	en in Part I.					robably 4 Unknown
Sor	w requir been s should	eted	prostate	cancer	<u></u>						24a. Was			utopsy findings available
Be	he law e has ige 2 :	Completed	[1000) 04 -	2-72							auto	psy ormed?	prior to death?	completion of cause of 2 □ No
ta	an; T rtificat tor, pe	Be Co	25. Was case referred to medical						26. Place of	of Death	1 □ Yes (Check only o		1 L 10:	3 2 1140
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o u	ing Pl	Uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury <i>Day, Year)</i>	28b. Time o Injury		28c. Inju Wor	k?		8d. Describe	how injury	occurred	
isio	dea h	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Iniury - At h	ome, farm, st	M reet, facto]Yes 2□N		8f. Location (Street and	Number or R	ural Route Number,
Division of Vital Records,	alor A saer il Direa	Certification: To	4 Homicide determined	building,	etc. (Speci	fy)	,	,			City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours are dea h. To the Funeral Director After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 ✓ Certifying Phy (Check only one)	sician: To the be iner: On the basi and manner	s of examina	owledge, deat ation and/or in	th occurr nvestigati	ed at the toon, in my	ime, date and opinion, deat	d place, a	and due to the	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	6			2		se number			29d. Date	signed (Mon	th, Day, Year)
			Milme		ND			D	6084	12		4,	13017	
	15 V		30. Name and address of person who c			m 23a) (Type,	Print)	2010	110	(7	000	1000	ne N	0 2/230.
	J *		VAIBHAV PARE 31. Date filed (Month, Day, Year)	KH M	ジ・ (istra/s Signs	147 S	• • • • •	77 V U	ver.	٥/٠	15/16)	110-01	7,	. –
	Sta	ite	MAY 0 1 2009	To acces to	8 4	Jacker								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Donald Joseph Hladky Sr. 25, April 2009 11:55 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1**X** M 2□ F 25, Maryland Director 215-64-4838 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No **Funeral Director** Baltimore Highlands Baltimore MD 10g. Citizen of What Country? 10e. Street and Number United States 21227 2811 Virginia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No White Specify: Be Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Insurance Sales Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Mary Bradley Louis Lawrence Hladky မ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2811 Virginia Avenue, Baltimore, MD 21227 Judith Hladky --Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of ceimetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State
4 Donation 5 Other (Specify)

Signature of Funcial Service Michaeles Important: If It any injury or o Department of 4-30-2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 WL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dian to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1∐ Yes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) Apvil 26, 2009 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of Jean (Item 23a) (Type, Print) Charles St. Balto. Md 2120% 32 Registrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

April 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Ye ar **Physician** 4:38 PM M <u> 20</u>09 28 04 George Washington Isom /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland
If Under 24 Hrs. Harford 736 Falconer Road
5. Social Security Number 6. Sex Joppa, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 01/11/1927 West Virginia Director 82 235-30-9194 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be netitied at 1 ☐ Yes 2 ☑ No Director Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 736 Falconer Road 21085 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorced White WW II Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within Elementary/Secondary (0-12) College (1-4or 5+) General Motors Corp. Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Lillian Mary Burks ပ Charles C. Isom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 736 Falconer Road - Joppa, Maryland George C. Isom (son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 05/02/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Ligensee R. 11750 Belair Road - Kingsville, Maryland 21087 assakn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Physician corona disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes R☐No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 29 2009 032299 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dov. CITW- moetha. 32. Registrar's Signature 31. Date filed (Month, Bay, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

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Physician		gistrar Decedent's Name (First, Midd	le,Last)					2. [Date of Death Month Da	y Yea		Time of De 1057 hrs	
al Examine	er	Allan R. Jud	У					A	Month Da April 11, 2009	4c. County			
	48	. Facility Name (if not institution	on, give street and r	number)	4	b. City, Town, or L Baltimore	ocation of t	Death					
		2508 Banger Street					If Under 2	24Hrs 8	. Date of Birth (N	/M/DD/YYY	y) 9. Birthpl	ace (State	or
Funeral	5.	Social Security Numberunk	6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	Hours	Min			Foreign	^{ry)} Mary	
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	U	sual Residence of Decedent		Idon City To	own or Locati	00					10	d. Inside C	City Limits
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laryla 28a-f	Director	0e. Street and Number	b			2123	0			US	SA		
the N		2508 Banger S			40.38/-	as Decedent of His		n? (Spec	ify Yes or No-	14. Rac	ce - America	n Indian, B	lack,
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death or ite must	اج	X	1 Yes	s 2 X No	1 1	Yes 2 X No	specify:			Specify	white	2	
after al", o	<u>a</u>		ivorced If Yes, Give or Dates:		10 Director	ette House Occupat	on (Give k	ind of wor		6b. Kind of E	Business/Inc	lustry 1	ınk
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5-UU30 iled within 7 Hygiene. I other than	ompleted	17. Father's Name (First, Midd	le Last)						First, Middle, Ma		ne)		
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Z1Z1 Z1Z1 Muld be fi Mental I marked ic event,	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or								er, City or To	own, State,		
shoul and N and S is n	ř	Sharon Nalba	ach/siste	r	1				altimore	, MD	21230		
Baltimore, MID 21215-UU30 The state of the Manyland following the death with the Maryland Department of Health and Montal Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	-	20a. Method of Disposition			Place of Dispo rematory or o	sition (Name of ce	metery,		Date	20c. Locatio	on - City or I	OWII, State	•
of H rite			ion 3 Remov	ral from State	rematory or c	iller place)							
Baltimore, permit. Pages 1 ar Department of He Important: If ite	-		Specify:	1/10	22.	Name and Addres	s of Facility	у		- 1		<i>a</i> .	
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	-	220 Port Enter the disease	or complications th	nat caused the death.	Do not enter	the mode of dying	, such as c	ardiac or	respiratory arre	st, shock, or	heart	LAPPIONIT	nate Interva Onset and
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month APRIL Day **Physician** 28, 2009 27:45AM Kathleen C. Jay /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Center Joseph Medical | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov 12, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Pennsylvania 88 Director 204-05-3504 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widterl Evanting Trust be notified at once. MD 1 ☐ Yes 2√☐ No Baltimore Owings Mills Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7907 C Valley Manor Road 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: White 1 □Yes 2X No ò 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) admitting officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrud C. Smith Charles A. Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Belden Court Timonium, MD 21093 Carol E. Connor/daughter in law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 ☐ Other (Specify) 21. Signat of June 1 service icensee ade State Anatomy Board 655 W. Baltimore Street S rector Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2**⋈** № 3 Probably 4 Unknown 1 Tyes Completed dehydration 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Be Certification: To

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760, attending p cate has been signed by the a page 2 should be detached it Division of Vital Records, certificate ! funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. the

Saltimore, Maryland 21215-0036

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25. Was case referre	ed to medical					2	6. Place of De	ath (Check only one)			
examiner?	lo	Hospit	1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury a Work? 1 ☐ Ye	at s 2 □ No	28d. Describe how injury of	occurred		
3 Suicide 4 Homicide	6 Could not be determined		e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	et, facto	ory, office		28f. Location (Street and I City or Town, State)	Number or Rural Route Number,		
00- 0	A considering Die		. To the book of my kn	auladga daath	00011111	ad at the time	date and place	e and due to the cause(s) a	and manner as stated		

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29b. Signature and title of c	ertifier		
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The Certifying Physician: to the best of my knowledge, dean occurred at the time, and due to the classes of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29c. License number 8 00 2 D37254

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DRIVE TOWSON, MD 21204 OSLER 31. Date filed (Month, Day, Year) TM 7601

State Registrar

Medical

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month **Physician** 2009 10:55pM 04 28 Jackson /Medical James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑** M 2□ F NC Director 243-40-6228 82 26 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò U.S.A. items 23a 21206 Funeral 4908 Midline Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No Specify: ₫ Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within a nand Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Reserve Security Officer 4th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Classie Jackson 2 Willie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an 5810 Loch Raven Blvd Baltimore, Md 21239 Carolyn Harris-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) :5/6/09 Enfield,, NC Enfield Memorial 22. Name and Address of Facility March F/H West Signature & Funeral Service License 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme if te Cause (Final **Physician** DEMENTIA UFARS e or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 X Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Division of Vital Records, completely filled in by the funeral the Hospital or Attending I hin 24 hours effer death. the Funeral Director Affer within 2

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 29c. License number D64395 APRIL 30, 2009

N CHAPLES ST. SUTTE 209 BATTMONE, MD 21204

29b. Signature and till

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Ε. Johnson 1:48a.^M Richard 25 2009 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 3229 Yosemite Ave If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠** M 2□ F 213-32-4351 Director 08 12 36 SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 □ No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 Completed by Funeral 3229 Yosemite Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ▼No Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Superior Transfer Elementary/Secondary (0-12) College (1-4or 5+) Inc. Truck Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ဥ Geneva Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Johnson-Wife <u>3229 Yosemite Ave, Baltimore, Md 21215</u> 20c. Location - City or Town. State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 5/6/09 Owings Mills, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) culor arrhythmia **Physician** Minutes Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine -oronary Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lung 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

/Medical Examiner Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi physician the burial attending p for use as t signed by the a certificate has lirector, page 2 s 24 hours after death.
 Funeral Director: After this certific letely filled in by the funeral director, within 24 hou To the Funer completely file the

the Maryland

with 1

show

ral", or items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23.
ury or other fraumatic event, the Medical Examine mala.

Baltimore, Maryland 21215-0036

Medical Certification: To

State

Registrar

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

imore Mo 21201

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

treet

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day 2009 Physician 27, 9:45 P.M Michael J. Kwiatkowski, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Middle River West Kingston Park Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 79 July 27,1929 220-22-5138 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Middle River Md. Balto. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 W. Kingston Park Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1952-1960 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lithographer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi Michael F. Kwiatkowski Mary Krawczynski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important; If Item 27 is
any Injury or other tra <u>Michael B.Kwiatkowski</u> 721 Northrop Lane Middle River, Md.21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-29-2009 | Balto. City, Md. Bayview 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 200 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ PERIPHERAL VASCULAR DISEASE 1 X Yes 2 No 3 Probably 4 Unknown has been s le 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 after death. Director: After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0032186 Thead May Key 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ION GREENE ST., BALTIMORE MD 21201

CONRAD MAY M.D. BALTIMORE VAMC

MAY 0 1 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Clever

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April $2^{\frac{D_{ay}}{9}}$ 200[°]9^{a1} **Physician** 4:33 Margaret L. Kvarda Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 1, 1940 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T F Maryland 68 212-38-0889 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Marylan 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be rediffed at once. 1 ☐ Yes 2 No Directo Harford Bel Air Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 640 Gairloch Place 21015 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorriane Misskelly ပ Frederick Bailev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 640 Gairloch Place Bel Air, Maryland 21015 James E. Kvarda, Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/30/09 Baltimore, Maryland 21. Signature of Funeral Service Lichisee
Thomas Gregor ²²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DIST 2 months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, & Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (Varda, Margaret Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-29-2009 10056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Birnbaum m.

MAY 0 1 2009

asm 31. Date filed (Month, Day, Year)

0.D. April 29, 2009

32. Registrar's Signature

Chesapeake Dr. Beldir, mp 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day APRIL 28, 2009 30 JOHN F. KETCHUM, SR. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A OVERLEA HEALTH & REHAB. Baltimore City Date of Birth (Month, Day, Yea 6/3/1915 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1**X**□M 2□F MARYLAND 213-10-7307 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes 2 □Xlo PARKVILLE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 1812 GLEN RIDGE ROAD 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Armed Forces: TYPY'es 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. WHITE 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BENDIX TECHNICAL WRITER 4 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AGNES FALKENHAYN JOHN W. KETCHUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1812 GLEN RIDGE ROAD BALTIMORE, MD 21234 ROBIN KETCHUM/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 7/17/2009 | ARLINGTON, VA CEMETERY2. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service icensee MO 1 139 21286 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Da allingousia

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Man

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

d other than "natural", or items 23a or 28a-f shovevent, the Medical Examination is ust be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

and attending physician Be Completed by Physician/Medical the signed by t been : certificate has completely filled in by the funeral director, page 2: e Hospital or Attending Physician; 1 124 hours after death. 9 Funeral Director; After this certifical Certification: To

Division of Vital Records, P.O. Box 68760,

certificate be

To the within 2 State

Medical

29b. Signature and title of certifier

iled (Month, Day, Year,

MD

resulting in death)	Du to (or as a consequ	terce of).			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	trition			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pregna Live birth 2 Feta Pregnant at time of d	I death 3 🗆 Ectopic pr			23d. Date of delivery Month Day Year
Part II. Other significant conditions con	-11	ulting in the underlying ca	use given in Part I.		o use contribute to the cause of death? 2 No 3 Probably Unknown
	10			24a. Was an autopsy performed 1 □ Yes	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DC	A Other: Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Map fler of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of 2 Injury M	Bc. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how in	
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory	office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occurred	at the time, date and place	ce, and due to the cause	e(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

04-28-2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Apri Year **Physician** Larcz 200 Jolones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Brightview Assisted Living | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | May 30, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mar vland 1 □ M 2 □ F 213-20-6002 84 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experience must be rutified at 1 ☐Yes 2 ☐ No Director Catonsville Md. Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 912 South Rolling Road 21228 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 🗵 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7 and Mental Hygiene.

marked other than "r Elementary/Secondary (0-12) 12th College (1-4or 5+) Secretary BGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth William M. Bak Helen Kowalski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet Stock (Daughter) 5115 Ilchester Road Ellicott City, Md.21043 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cem 5/4/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caczorowski Funeral Rome, P.A. 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stock *Disease* **Physician** nd disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, rany, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) the burial-P.O. Box 68760, physician Physician/Medical for use as attending IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 □ Yes 2 □ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 26. Place of Death (Unex Unity Unity)
Other: 4 □ Nursing Home 5 □ Residence 6 ○Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sigratore and title of certifier 29c. License number D0053337 Does 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown Md 21136

State Registrar Secry

31. Date filed (Month, Day, Year)

OM,

25

32/Registrar's Signatus

Main

DHMH 17 Rev 1/2001

Street

Suite 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland	/ Depa	rtment of H	ealth ar	nd Mental H		2009	14024	
			Registrar 1. Decedent's Name (First, Middle, La.	st)			Timoute of E	- Cuiii	2. Date of D			3. Time of Death	
	Physicia		Ruth	m. 1	eese				Month APOIL	Day 27	2009	13:25 PM	
24/4	/Medic		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of [Death	4c. C	County of Deat	h	
-	,		Johns Hopkins Bayvien				Baltimore				N/A		
	Funeral		5. Social Security Number 6. S 217–18–1361	ex 7.Ag	e (In yrs. las 85	st <i>birthday)</i> , Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Month 1 July 1	irth Jay, Year 3	9. Birt Co Mar	thplace (State or Foreign suntry) Yland	
	Director		Usual Residence of Decedent						puly 1	0, 10	25 trai	y Latte	
yland	WO #		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
Mar	s j-e	cto	Maryland Baltimor	e		Dund	alk					1 □ Yes 2 X No	
ifi th	or 28	Director	10e. Street and Number				10f. Zip Code				en of What Co	ountry?	
ath w	s 23a	eral	2032 Barry Road	1 10 111		Link	212		0.40		USA	ada an fa di an	
er de	item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2		13. \	Was Decedent of His f Yes, specify Cubar	spanic Origir n, Mexican, F	Puerto Rican, etc.)	10-	 Race - Ame Black, White 		
036 Irs aff	al", or	Ğ.	3√ Widowed 4 Divorced	If Yes, Give Year or Dates:		1	∐Yes 2√∏No	Specify:			Specify: Wh	ite	
21215-0036 dwithin 72 hours after death with the Maryland	natura fical B	Completed	15. Decedent's Ed (Specify only highest gra	ducation			dent's Usual Occupa kind of work done di		f working	16b. Kin	d of Business/	Industry	
21:	ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT use retired)	_		E a d a	1 Co.		
2 2 1 2 1 W	her ti		17. Father's Name (First, Middle, Last,		1	Admin:	istrative		Name (First, Midd			vernment	
Maryland	ed of) Be	James Dolle	'					Clarke	c, maideir c	ramame,		
I Z	mark mark imatio	၉	19a. Informant's Name/Relationship (Type. Print)	- 1	19b. Mailin	g Address (Street a			ber. City or	Town, State, 2	Zip Code)	
Nd 2.5	alth a 27 is ertrau		Laverne Stumpf,		1		Barry Roa						
Baltimore,	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Existinat must be notified at once.	1.5	20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other place	9)	Date	20c. Loc	cation - City or	Town, State	
Page	ment ant: if ury o		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		o Cre	matorv Ir	nc. 0	4/30/09			Maryland	
Salt ermit.	Depart Import any inj once.		21. Signature of Funeral Service Line	Ju-		C_{r}^{22}	Name and Address	s of Facility	y Of Mary	land,	Inc.		
ш а			Thomas Gregor								d, Inc. , Maryland 21228		
		. 79	shock, or heart failure. List only	one cause on each li	ne.		er the mode of dying, such as cardiac or respiratory arrest,					Interval Between Onset and Death	
	ysician Jedical		Immediate Cause (Final disease or condition resulting in death)	a. Respira							4 hours		
	aminer			Basilar								5 days	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as									
Cuted cuted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause Electroceryl, cause (Disease or injury that initiated events	C.									
3760, ₂	ian ar ırial-tr	Exc	resulting in death) Last	Due to (or as	a conseque	nce of):							
876	physic the bu	dical		d									
I Records, P.O. Box 68760,	attending physician and for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	21/					04 D-1(4-		
Box eath cer	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	,		2	23d. Date of de Month	Day Year	
P.O.	has been signed by the le 2 should be detached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown									
S, F	gned be deta	by PI	Part II. Other significant conditions	ontributing to death b	ut not result	ing in the ur	nderlying cause give	n in Part I.				o the cause of death?	
ord:	en siç ould b	ed k	** T-1-17						1[Yes 2]No 3 P	robably 4 Unknown	
Records,	as be	plet							24a. Wa	ODSV	24b. Were au	utopsy findings available completion of cause of	
T The	ate	Completed							pe	formed? 2 No	death? 1 ☐ Yes	2 No	
of Vital Physician: T	within 24 moust ared open. To the Funeral Director: Atter this certificate in completely filled in by the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Otho		f Death (Check only	one)			
Of Phys	r this ral dir	<u>۲</u>	1 Yes 2 MNo 27. Manner of Death	1 ☑ Inpation		R/Outpatier	t 3 DOA Olle		ing Home 5 Re			ecify)	
Ou	Atte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, Year)	Injury	Work	? ′es 2∐No	i	o now injury	Goodifed		
Division I or Attending	ector:	ifica	3 Suicide 6 Could not b	28e. Place of Inj	ury - At hom	ie, farm, str	eet, factory, office					ural Route Number,	
Di	s arre	Certification: To	4 ☐ Homicide determined	building, et	c. (Specify)				City or I	own, State)			
lospii	unera unera ely filla		29a. Certifier (Check only 2 Medical Example 1	nysician: To the best miner: On the basis of	of my knowl	ledge, deat	n occurred at the tim	ne, date and	place, and due to the	ne cause(s)	and manner a	s stated.	
the F	the F	Medical	one)	and manner st									
P]	2 00		29b. Signature and title of certifler				29c. License				e signed (Mont		
				nomplated are a	looth /lt f	200) /T	Deinal						
	3		30. Name and address of person who Brian Itoward Mi) 496	10 F.	· ten	1. 3.	Homo	re, mD	2127	24		
	Sta	te	31. Date filed (Month, Day, Year)	62. Registr	ar's Signatu	re							
	Registr	ar	31. Date filed (Month Day, Year) A Y 0 1 2005	Senera	A.	par	the state of						
DHMH	17 Rev 1/2	001					SINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 Physician 4c. County of Death 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Social Security Number perember 31928 1 M 2 X Funeral 183-22-4310 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

of: If item 27 is marked other than "natural", or items 23a or 28a-f show 1 XYes 2 ☐ No Examiner must be notified at Altimore Director iland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21207 2121 Windsor aeden Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Funeral Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No Black, White, etc 11. Marital Status 1 ☐ Yes 2.4 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. AMERICAN African Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Nurse 18. Mother's Name (First, Middle, Maiden Father's Name (First, Middle, Last, Georgia Was Be 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Garden lane-DAHIMCIE MARYLAND 2607 Windson ecla 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition MAY 05,2009 1 Burial 2 Cremation 3 Removal from State Saltimo Re UES-tERN 4 ☐ Denation 5 ☐ Other (Specify) SURU, CE NANCY M. WALLACE FUNCEAL SECTIONS WARYLAND ure of Funeral Service Licenses 21. Siggs 23a. Pt 1. Ent r v. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirty in the vitalium. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Due to lor as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and ld be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23d. Date of delivery IF FEMALE: yes, outcome of pregnancy Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant Month 2 - Fetal death Live birth in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) Pregnant at time of death 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2 No ð Completed 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should completely filled in by the funeral director, page 2 should 24a. Was an autopsy performed 2 🗌 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 5 Residence 6 Other (Specify) examiner? 4 Nursing Home 3 DOA 1 | Inpatient 2 ER/Outpatient 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Medical Certification: Injury I or Attending P 5 Pending investigation 1/1X Natural 1 🗌 Yes М 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 - Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e Hospital of 24 hours a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 289000

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Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 01

parke

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Campbell

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Maryland / D	Department of Ho Certificate of E			2000	11.026
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	realli	Reg. No 2. Date of Death		3. Time of Death
Physici /Medi		MATHIAS JOHN	LIEB			Month Da		1:43 AM
Examir		4a. Facility Name (If not institution, give si	reet and number)	4b. City, Town, or I	Location of Death	40	. County of Death	
Francis		5. Social Security Number 6. Sex	HOSDITAI 7. Age (In yrs. last birth	Daltin hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birtho	ace (State or Foreign
Funeral Director	ı			Yrs. Months Days	Hours Min.		5 MAR	TCAND
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				od. inside City Limits
Marylan -f show fied at	tor	MARYLAND BALTIMOR	9. PARKY	1118				1 □Yes 2 No
th the or 28a anotil	Jirec	10e. Street and Number		10f, Zip Code		10g. Ci	tizen of What Coun	try?
ath wi	rai	2611 WENDOVER	AVENUE	2122		<u> </u>	1. H.	
ter de	Funeral Director	11. Marital Status 1 ☐ Merried 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Ye's or No- Rican, etc.)	14. Race - Americ Black, White, e	
rai", or	þ	3 M Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □Yes 2 W No	Specify:		Specify: WH	TE
"natu	Completed	15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occupa (Give kind of work done do life. DO NOT use retired)	tion uring most of worki	16b. k	(ind of Business/Inc	ustry
withir jiene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	IDUSTRIAL	ENGINE	ER CRO	WN cort	+ SEAL CO.
al Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maider	Surname)	731
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evantines must be notified at	2	JOSEPH LIEB			THEKE	Sti SCHN	EIVER	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantice must be notified at once.		19a. Informant's Name/Relationship (Typ	/NIECE 74	Mailing Address (Street a	RAPAD	JOHPA MA	or rown, State, 21p KYLAMO	21085
es 1 ar of Hea fitem rothe		20a. Method of Disposition	cemeter	Disposition (Name of y, crematory or other place		pate 20c. L	ocation - City or To	wn, State
trnent tant: I		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State ORULO R	UPGE CEMETE	RY 5-2-	2009 PIK	ESVILLE.	MARYLAND
permit Depar Impor any In		21. Signature of Funeral Service Licensee	MILLA	22. Name and Address	s of Facility 380	HAKEORD ROLL	AD PHKKVIUG	c, MD 21234
_		23a, Part 1. Enter the disease, or complic	ations that caused the death. Do n	ot enter the mode of dying	, such as cardiac	or respiratory arrest,	OGNICA	Approximate Interval Between
Physician		shock, or healthailure. List only one Immediate Cause (Final disease or condition	Sepsis					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence o	•				-
	ē	Sequentially list conditions, b.	Aspiration Due to (or as a consequence of	pneumonia	- 4		- 0	
cuted nd ransit	Examiner	Gause (Disease or injury that initiated events c.		•				
icate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	of):				
fficate g physi s the t	edical	d.						
eath certific attending p	M/Ne	23b. was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy			23d. Date of delive	*
the att	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)			Month	Day Year
that the		Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause give	n in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
quires an sigr uld be	ed by	Coronary artery	disease			1 ☐ Yes 2	. □No 3□ Prob	ably 4 ☐ Unknown
law re las bee 2 sho	Completed	chronic renal	insufficiency			24a. Was an autopsy		psy findings available inpletion of cause of
sician: The law certificate has l irector, page 2 s			•			performed? 1 ☐ Yes 2 ☐ N	death?	
s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ∏ inpatient 2 □ ER/Out		26. Place of Death	n (Check only one) me 5 ☐ Residence	C Clother (Or self	,
ng Phy ter this neral c	I I− 1	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury	at :	28d. Describe how inju		//
tendir leath. tor: At the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 □ Y	es 2□No			
lor At after c Direct	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Street a City or Town, Stat	nd Number or Rura e)	I Route Number,
To the Hospital or Attending Physician: The law requires that the death certif To thin 24 hours after death. To thin Experient Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	i cian: To the best of my knowledge er: On the basis of examination and	, death occurred at the tim	e, date and place,	and due to the cause(s) and manner as s	tated.
the H thin 24 the F mplete	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License			ate signed (Month,	
7 ≥ 6 8			A. D.	RES		290. D	4/29	2009
الماير		30. Name and address of person who con	npleted cause of death (Item 23a) (Type, Print)			1-11	
32,		FANG YIN 560	Loch Raven B	Ival Good S	amarita	n Hospital	Beutime	re, MD 21239
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature					

DHMH 17 Rev 1/2001

Lieb, Mathias vate of birth os,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 April 29, 7:33 P^{M} George Douglas Lominac /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mapthe Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 12XM 2□ F 239 44 6178 Kentucky Oct.27,1933 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exp. injury must be could be an once. 1 ☐ Yes 2 No Middle River Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21220 7 Runway Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1051 11. Marital Status 1 Mayes 2 No 1951-If Yes, Give Year or Dates: 1953 Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Meat Cutter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Blanche Hamlin Lattie Buck Lominac 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Runway Court Baltimore, Maryland 21220 Bobbie Jean Lominac (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory Inc. 5/2/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. Maryland 21221 1407 Old Eastern Avenue Essex, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? s after dea. ral Director: Aftr 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

29b. Signature and title of certifier

Date filed (Month, Day, Year)

Gosne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Registrar's Signature

Suite SSO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I for per fh 8891 5-1-09 yt State of Maryland? Department of Health and Mental Hygiene [] [] 9 14028

			_ State Registrar		Cer	tificate of L	<i>Death</i>		Reg. No.		
			1. Decedent's Name (First, Middle, Last)					2. Date of D Month		Year	3. Time of Death
	Physicia		Fannie	LaNae		Le	ake	04		009	2:15a.M
	/Medic Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County o	f Death	
	Examini	CI.	Manor Care Nurs			Baltin	nore				
-	Funeral		5. Social Security Number 6. Sex		irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Birthp	lace (State or Foreign
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			Usual Residence of Decedent				1	02 1	<u> </u>		
	ow Dw		10a. State 10b. County	10c. City, Tov	vn or Loc	cation				1	0d. Inside City Limits
	/ary	0	MD NA	1	Balt	imore					1 X es 2 □ No
1	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
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:	s 23	Funeral	3325 Dolfield Av		10.1			nacify Vac or N			can Indian,
-	item item	Š	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. 1	Vas Decedent of Hi f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black	, White,	
36	illed within 72 hours after death with the Maryland Hygiene, When than "natural", or items 23a or 28a-f show ther than "natural" or items 23a or 28a-f show ent, it e in edical Examination must be mailfed at	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give	1	□Yes 2□No	Specify:		Specify:	B.	lack
8	ural'	5		Year or Dates:	- D	lent's Usual Occup	otion		16b. Kind of Bus	einoee/In	duetry
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ם	d oth	Be	17. Father's Name (First, Middle, Last)							7)	
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a	2 sho l and is ma rauma		19a. Informant's Name/Relationship (Ty						ber, City or Town,		
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Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It of Medical Examinet must be available at		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other plac	re)	Date	20c. Location - 0	City or To	own, State
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å	permit. Pages 1 and 2 Department of Health Important: If item 27 is any injury or other tra		MILL B	K.o.k	M.	arch F/	H West	D = 7.4		ма	21215
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ledical	(Check only 2 Medical Exam)	sician: To the best of my knowled ner: On the basis of examination	lge, deat and/or in	h occurred at the ti	me, date and place opinion, death occu	e, and due to t urred at the tim	he cause(s) and ma ne, date and place, a	anner as and due	stated. to the cause(s)
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	.\		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type,	Print)	1 1	1.0 /	1.0.1	7	11) 21234
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DHMH 17 Rev 1/2001

For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03268 State of Maryland / Department of Health and Mental Hygiene James Hugh Miller Certificate of Death 1- For State Reg. No. 2. Date of Death Registrar . Decedent's Name (First, Middle,Last) Physician/ 1641 hrs April 23, 2009 James Hugh Miller **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford BelAir 1726 Churchville Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Foreign **Funeral** Months Days Hours Min Country) 07-31-1957 51 Director 1 X M 2 F 218-70-5987 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State any Yes 2 X No Bel Air f show Harford permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1726 Churchville Rd 21015 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. Armed Forces? 2 Married Never Married 2 1 X Yes White Yes 2 X No specify: Specify: If Yes, Give Yea 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 2 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Co. 21215-0036 Bricklayer 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Marvin Eugene Harris Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12339 Belair Rd Kingsville, MD 21087 Baltimore, MD Allan Eugene Miller (Brother) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 04-30-3009 Baltimore, MD Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line 21014 Approximate Interval Retween Onset and **Physician** failure. List only one cause on each line Death **Medical** a. Hanging Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and . transit Physician/Medical AMENDED UNPENDED ending physician use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown for 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ó Yes 2 ✔ No 3 Probably 4 Linknown ģ يم 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records. page 2 should prior to completion of cause of certificate has been autopsy performed? death? Yes No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: director Be Other₄ Residence 6 V Other: Scene Hospital: Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 Yes ٥ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject hanged himself Certification: FOUND Yes 2 V No Natural Pending 24 hours after death. Apr 23, 2009 1625 hrs the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 1726 Churchville Road, BelAir, MD 3 V Suicide Could not be determined (Specify) Garage 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 2 29c. License number 29b. Signature and title of certifier April 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Registrar's Signature 31, Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 9 11:45FM Mary G. Miller **Physician** APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Tawsan Saint Joseph Medical Center 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April 1 4ear 1918 7. Age (In yrs. last birthday) _____ 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 □ M 2 □ XF 213-34-1487 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedley Example at Glen Arm 1 ☐ Yes 2 X No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21057 USA 11630 Glen Arm Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary G. Feniour Frederick H. Leiss other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type. Print) 34 Sparks Farm Road Leonard Miller/ Son 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, injury or Gardens of Faith 05/01/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Connelly Funeral Home Avenue Baltimore of Essex MD 21221 21. Signat re of F negal Service 23a. Part 1 Enter the disease, or comparations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner ARTERIAL DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Fctopic pregnancy Month Year 5 Other (specify) ned by the a 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ş Q page 2 should be 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours aft To the Funeral Di completely filled in

31. Date Hed Worth, Day, Year, HELOUS MD 7671 OSLER DRIVE TOWSON, MD 21204 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

close, M. D

29b. Signature and title of certifier

29c. License number

DØØ17695

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1359PM **Physician** APRIL Wanda Jean Metcalf 24 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev Ye Aug. 30) BALTIMORE AGNES HOSPITAL 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1950 **Funeral** Mary land 1 ☐ M 2 🖫 F 220-66-0369 68 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Expranal Permanatic and once. 10a. State 1 ☐ Yes 2 ▼No Director Baltimore Arbutus MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 United States 1417 Sulphur Spring Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Specify: White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Glass Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Sexton Mary Castle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Sulphur Spring Rd., Arbutus, MD 21227 19a. Informant's Name/Relationship (Type. Print)

John W. Johnson, Jr - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition

☐ Burial 2 Cremation 3 ☐ Removal from State 5-1-2009 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final De to (or as a consequence of): Physician 2 marks disease or condition resulting in death) /Medical Examiner 2 montes peritivitis Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be execu Due to (or as a consequence of): the attending physician Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Nknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☑No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 24, 2009 D0065409 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD21229 900 CATON STASZAK AVE. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 2009 Margaret A. Martin 12 A M /Medical 4c. County of Death Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death Examiner omico If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. Funeral Days Min/ 1 □ M 2 🕅 F 70 214-34-8988 Aug 12, 1938 Director Maryland Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at MD Wicomico 1 ☐ Yes 2 ☐ No Salisbury Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 511 Bethel Street 21804 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: à white 3 N Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Lound be filed and Mental Hygie.
The straumatic eventation of traumatic eventations. cleaner/cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Dallas Ruark Margaret Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Angela Jarvis/niece 9305 Calvary Cricle Salisbury, MD21801 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' permit. Pages Department of Important: If if any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street S. Wade, 21. Signature of superal Survey prector Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Enter lorge scales and the death.

District of the disease of the disease of the district of the disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** DISPASC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties of the second 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.

E Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. the 29d. Date signed (Month, Day, Year) Signature 29c. License number Name and oddress of person who completed cause of death (Item 23a) (Type, Print) oas to 31. Date filed (Month, Day, Year) State MAY 0 1 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland		rtment o <i>tificate</i>			ental H	ygiene Reg. No	ABE	1.0	11.023
			Registrar 1. Decedent's Name (First, Middle, Las	st)			············	0, 000		2. Date of I	Death			3. Time of Death
	Physici /Medic			MAYS						APRIL	-		09	2:35 P
	Examin	er	4a. Facility Name (If not institution, given GILCHRIST HOSPI				4b. City, Tov	vn, or Locati OWSON	on of Death		40	County of IBAL	Death TIMO	RE
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. la:	st birthday)	If Under 1 \		der 24 Hrs.	8. Date of I	Birth Day, Year,			ce (State or Foreign y)
	Director		218-28-6644 Usual Residence of Decedent	□ M 2 X F	76	Yrs.	WOTHIS	ays 1100	Nilli.	MAY 1	3, 1	932		NC NC
	yland Jow		10a. State 10b. County		10c. City,	Town or Loc							100	I. Inside City Limits
	e Mar	Director	MD			BALT	IMORE				,			1X Yes 2 □ No
	with th	Dire	10e. Street and Number	TE ATOM	201		10f. Zip Co				10g. Ci	itizen of Wha US		y?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Examinar must be redified at	Funeral	6600 EBERLE DRIV	12. Was Decedent E	t Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify						No-	14. Race	America	
36	or ite	by Fu	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, et No 1 □ Yes 2 No Specify:							Specify:	Vhite, etc	
21215-0036	hours atural"	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	: 16a. Decedent's Usual Occupation						16b. k	Kind of Busin	BLA ess/Indu	
215	thin 72 e. Marin	Completed	(Specify only highest gra	ide completed) College (1-4or 5-		(Give k life. D	ind of work o O NOT use i	lone during i etired)	most of workin	g				
	led wil Hygien her th		17. Father's Name (First, Middle, Last)	5+			ГЕАСНЕ		other's Name	(Eirst Mide	llo Maido	BCPS		
anc	d be fi ental h ked ot	To Be	JOSEPH KNIGHT							GRAY	ne, maruer	n Surname)		
arv	and M is mar	۲	19a. Informant's Name/Relationship (imber or Rural					
F 7	and 2 Health Im 27 in		KEVIN WOODS/ SON	<u> </u>	Took Die		601 MA		AVE.			ocation - Cit		MD 21217
ユ新ル Baltimore. Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machinal Examination into the traumatic event, the Machinal Examination into the profile of the page.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □		cer	ice of Dispos metery, crem	atory or othe	r place)	1	2009				MARYLAND
Cl #	mit. P partme sortan / Injur.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		KII		Name and A							F.H., INC.
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2009			23a. Part Enter the disease, or com show, or heart failure. List only	plications that * used one cause on each line	the death.	Do not ente	A 4			respirator	y arrest,		1	Approximate nterval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	IIVL	non of):	10.9	re	MA				M	ronths
6	Examiner			b - Due to (or as a	Conseque	ence or).								
d	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or as a	i conseque	ence of):							-53	
3/m	executions and all-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	conseque	ence of):								
2092	icate be executed physician and s the burial-transit			_ d										
Z,89	certifica Iding ph	Physician/Medical	IF FEMALE:											
5 8 8	death c	cian/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2 Pregnant at	2 🗀 Fetal o	death 3 🗌	Ectopic preg					23d. Date of Month		y Day Year
\$ 0	that the died by the detached	hysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown			Caron (open	·// ———						
550 L	e law requires that the death carifife has been signed by the attenting to 2 should be detached for use as	by P	Part II. Other significant conditions of	contributing to death bu	t not result	ting in the un	derlying caus	se given in P	art I.			× 4		cause of death?
(A) (S)	requires been sign	eted			<u>-</u> -							7		bly 4 Unknown
Rec	The law ate has b	Completed			·				<u> </u>	24a. W au pe	itopsy informed?	pric dea	r to com	sy findings available pletion of cause of
ital	ian: T rtificat tor, ps	Be Co	25. Was case referred to medical					26. F	Place of Death	1 □Ye (Check on	_/	0 1 _	Yes 2	2 ∐No
of v	Physician: r this certific ral director,	၉	examiner? 1 ☐ Yes 2 No			R/Outpatient			Nursing Hon			6 Other	(Specify)	Waspile
	nding Path.	tion:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y , Year) 2	28b. Time of Injury	М 28с	Injury at Work? 1 □Yes		8d. Describ	e how inju	ury occurred		
Division	Atten r deatl ector: by the	Certification:	3 Suicide 6 Could not b	e 200 Place of Inju	ry - At hom	ne, farm, stre				8f. Location	(Street a	and Number	or Rural	Route Number,
Ö	tal or rs afte al Dire	Cert	4 Notfficial								Town, Star			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Ph	nysician: To the best on miner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at estigation, in	the time, da my opinion	te and place, a , death occurre	and due to ted at the tin	the cause(ne, date ar	(s) and manr nd place, and	ner as sta d due to t	ated. the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner sta	ied.		29c. L	icense numl	per		29d. D	ate signed (/	Month, D	ay, Year)
	->-		> Quart	h			D	158	303		A	かし	27	2009
	5		30. Name and ad ress of person who		eath (Item :	23a) (Type, F	rint	m : 6	1 01			7 77	7	CON MA
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		re lire	6/0	U/ r	V. U	NEVZLE	7 7	5	02	2011 (-11)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 2006 Moreland Patterson Annie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. Agnes tospitA1 BaltimoRE Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 244-56-9342 84 28 24 84 06 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm I'm dical Erain for it ust he notified at 1 ☐ Yes 2X No Catonsville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 21228 810 Bobby Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 XNo Specify þ Black 3X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince Georges College (1-4or 5+) 5yrs+ ene. Elementary/Secondary (0-12) County School System Teacher 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental F be Esther Young Pages 1 and 2 should the nent of Health and Men John W. Patterson Sr. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 1210 Borders Road, Shelby, NC 28150 James Patterson-Brother permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Arlington Hational 5/13/09 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 Baltimore, Md 4300 Wabash Ave, 23a. Par 1. Enter the tiltease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dou **Physician** /Medical consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Physician/Medical law requires that the death certificate as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ĮQ. in the past 12 months? 5 Other (specify) 1 □Yes 2 □No the 9 T Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 □No 2 No 1 ☐ Yes Division of Vital Physician: funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Dipatient Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and addres of perso pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 10:00 P M April McKenzie Lee Kevin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel 8139 Show Case Court Pasadena 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F March 4, 1957 Maryland 214-72-2144 52 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 8139 Show Case Court 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 □Yes 2 XNo 1 ☐ Yes 2 ☐XNo If Yes, Give Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Construction Supply Company Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Coates McKenzie Imogene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8139 Show Case Court Pasadena, Maryland 21122 Debora E. McKenzie (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/09 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enal Cell Curcinome zmos. Metasterry disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or selections of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ontribute to the cause of death? 3 Probably 4 Unknown Bb. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other (Specify)

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Physician

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Examiner

Funeral

Director

28a-f show

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or than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23:
ary or other traumatic event, the "Assistant Examples or the second of the state of the second of

Baltimore, Maryland 21215-0036

the Maryland

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Examiner burial-tra Physician/Medical

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Certification: To

Medical

2

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician sthe burial attending p for use as t cate has been signed by the page 2 should be detached certificate within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

1 ☐Yes 2 ☐No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)
	s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death
Diabetes Metil	24a. Was an autopsy findings ava prior to completion of cause death? 1 Yes 2 No 1 Yes 2 No
5. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 \[\text{Yes} \ 2 \ext{\subset} \ No
3 ☐ Suicide 6 ☐ Could not determine	

29h. Signature and title of certifier

(Check only

29a. Certifier

29c. License number 039660

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) April 28, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Baltimere, UND 21230 901 Fort 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 5:30 2009 HORACE EDWARD MILLER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) CARROLL CARROLL HOSPITAL CENTER WESTMINSTER Birthplace (State or Foreign Country) if Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1√2 M 2 ☐ F 81 MARYLAND 219-20-4954 9/13/1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No FINKSBURG CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21048 1883 DEER PARK RD. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married 1∐Yes 2∐XNo Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CARPENTER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ADA MAE GLOVER WILLIAM EZRA MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1883 DEER PARK RD., FINKSBURG, MD 21048 - WIFE DORIS R. MILLER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ty Burial 2 ☐ Cremation 3 ☐ Removal from State DEER PARK CEMETERY 5/2/09 SMALLWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. eral Service Licensce 21. Signature of MAIN ST., WESTMINSTER, MD 21157 23a. Part 1 Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC ENCEPHALOPATH disease or condition resulting in death) Due to (or as a consequence of): INTRACRANIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No DEEP VEIN THROMBOSIS 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending

Physician /Medical **Examiner**

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examirer must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the I ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a.
ury or other traumatic event, the Modical Examiner must be and the

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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that the death certificate be executed burial-transi physician s the burial attending p for use as t ed by the detached o of Vital Records, Physician: The

۵.

Division Hospital or Attending

Examiner Physician/Medical 2 Completed has page certificate Be Certification: To this After this funeral of nours after death.

neral Director: Af

filled in by the fur

1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier eloy M.D

investigation 6 Could not be

29d. Date signed (Month, Day, Year)

tem 23a) (Type, Print)

CARROLL HESPITAL CENTER LUES MINSTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBALLAH J. HELOU, M. D.

Registrar

31. Date filed (Month, Day, Year)

3 Suicide

29a, Certifier

4 Homicide

32. Registrar's Signature

within 24 hours a

To the Funeral C

completely filled

To the Pwithin 2

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,18&19a PEr Inf G891 5/15/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 3101 WILLIAM JOHN O'REILLY 009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of New try ersey 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1 X M 2 □ F 66 Director 151-30-9088 MAY 17. NEW 1942 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho 1 XYes 2 □ No Director MD CARROLL TANEYTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 304 CLUBSIDE DR. 21787 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No If Yes, Give Year or Dates Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 8 VETERINARIAN ANIMAL HOSPITAL i 2 should be filed w th and Mental Hygie 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname)

Margery Flavey O Reilly

MARJORIE

FALVEY 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev O'REILLY **JACK** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY M. CLUBSIDE DR., O'REILLY - WIFE 304 TANEYTOWN, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) MEADOW BRANCH CEM. 5/1/09 WESTMINSTER, MD Donation 21. I gnature of Funeral Privice Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 Ε. MAIN ST., WESTMINSTER, 21157 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final seless **Physician** 10115 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 051 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the detached 1 ☐Yes 2 ☐ No. 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Z NO Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 10 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

State Registrar

Medical

29a. Certifier

29b. Signature

(Check only one)

30. Name and address of

Kober-31. Date filed (Month, Day, Year) Registrar's

and manner stated.

person who completed cause of eath (Item 23a) (Type, Print)

1 🛄 effitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Vashington Kd

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23afti, II,25,27/Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:30 AM **Physician** 2009 Kevin Shirley Paige Apri /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner VAMARYLAND HEALTH CARESYSTEM PERRY Point CECIL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 48 Director 577-82-5367 Aug 18, 1960 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f shov DC Washington 1 □Yes 2√□ No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 611 Edgewood Street NE #524 20017 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

ty Yes 2 | No If Yes, Give Year or Dates: 179-82 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2X No 5-0036 Specify Specify: black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland f Health and Mental Hy 17. Father's Name (First, Middle, Last) Be Leon Noth Doris Paige ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VA MD Healthcare System 361 Boiler House Road Perry Point, MD 21902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wales 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 1 sel enn 21201 Baltimore, MD Aproximate Interval Between Onset and Death Part 1. Inter the disea 4, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Seizure Disorder Physician /Medical Due to (or as a consequence of): Examiner WED BY WEDICH! EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (o as a consequence of) nding physician ause as the burial certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Physician; The law requires Traumatic Brain Injury, Meningioma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
1 Yes 2 (No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 A Yes 2 To No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury a Unknown 28d. Describe how injury occurred Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No **Unknown**^M IInknown after death

Director: 2 Accident Unknown 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Discompletely filled in Unknown Unknown Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number Pennsylvan 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 24, 2009 MD0724921 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., VA MARYLAND HEALTH CARE SYSTEM, PEWY POINT, MD 21902 Bullock, DeborAh

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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KEVIN

PAIGE,

Physician

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ELMER PLUMHOFF APRIL 17:13 PM HENRY 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Months **Director** 212-36-2761 70 Nov. 08 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner, ust be netflied at 1 ☐ Yes 2 No Glen Burnie Director Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21060 U.S.A. 995 Point Pleasant Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 Midowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Salesman Fischer Auto Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end 2 should be lealth and Mental Henry Plumhoff Evelyn Ruby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. McKenzie (Daughter) 212 Allwood Drive, Glen Burnie, Maryland 21061 Shery1 Pages 1 (ment of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o o o occe. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 05-02-2009 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Point 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mm ediate Cause (Final cisease or condition resulting in death) **Physician** NEUMONIA /Medical Due to (or as a consequence of): Examiner METASTASIS SPAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit OF UNKNOWN Due to (or as a consequence of) Box 68760, Physician/Medical JE FEMALE: signed by the attendin I be detached for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 □ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2URES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 4 No 24a. Was an has autopsy performed? certificate funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 12 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2009 SOURABH VERMA, MD RES 000 2-8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S HANOVER STREET SOURABH VERMA BALTIMORE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

		1	State of Maryland / Department	artment of Health and M rtificate of Death	Reg. No 2 0 0 9 1 4 0 4
	Physicia	an	1. Decedent's Name (First, Middle, Last) Marcarot Flice Polok		2. Date of Death Month Day Year April 30 2009 3:00 a
	/Medic Examin		Margaret Elise Polek 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1			Stella Maris	Timonium	Baltimore
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
	Director	-	220–42–7829 G4 Yrs. Usual Residence of Decedent		Sept 25, 1944 Maryland
	yland Now		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Lim
:	a-f st	ctor	Md. Baltimore Cockeysv	ille	1 □Yes 2 ¬
:	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
:	s 23a	ra	10711 Lakespring Way	21030 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No- 14. Race - American Indian,
90	be lied within 72 hours after death with free maryland hatel Hygiene. Atel Hygiene. Ad other than "natural", or items 23a or 28a-f show event, it is it offer than it is a must be notified.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc. Specify: White
3	tural'	ed b	15 Decedent's Education 16a, Dece	dent's Usual Occupation	16b. Kind of Business/Industry
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7	d within giene. er than "	ĕ		ation Coordinator	Stella Maris
9	be filed y tal Hygi d other event, II	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
<u> </u>	should be and Menta s marked umatic ev	၉	Joseph W. Clautice		et Gunther
lar.	s 1 and 2 should f Health and Mer item 27 is marke other traumatic				al Route Number, City or Town, State, Zip Code) Cockeysville, Md. 21030
e '	1 and Health Sm 27 ther t				Date 20c. Location - City or Town, State
٥	ages int of t: If its		1 t⊵ Burial 2 □ Cremation 3 □ Removal from State	osition (Name of matory or other place)	00 Time Mil
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 g Department of Health a Important: If item 27 is any Injury or other trau		4 □ Donation 5 □ Other (Specify) Dulaney V 21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility	
n	Dep any		1/1/1/2	RUCK TOWSON FU	neral Home, Inc. Towson. Md. 21204
7	Cate be executed he executed by Alexander by the burial-transit the burial-transit the burial-transit by the b	l Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause fine death) Sequentially list conditions, if any, leading to immediate cause fine death) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		Interval Between Onset and Death
P.O. Box 6	es that the death certifigned by the attending be detached for use as	d by Physician/Medical		□ Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death 1 □ Yes 2 ▼ No 3 □ Probably 4 □ Unkn
or Vital Records,	law requir as been s 2 should	Completed			24a. Was an autopsy findings avail prior to completion of cause
ř	The la	E O			performed? death? 1 □ Yes 2 ▼ No 1 □ Yes 2 □ No
<u> </u>	sician: The certificate rector, pag	0	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)
> =	<u>%</u> .≊ i	To B	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		ome 5 ☐ Residence 6 【COther (Specify) HOSPIC
0	ne fe	ë.	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day, Year) 28b. Time Injury	Work?	28d. Describe how injury occurred
DIVISION	or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 □Yes 2 □No ltreet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
É	흐를들드	Certi	4 nomicide building, etc. (Specify)		
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only 2 Medical Examiner: On the best of my knowledge, de: One Nurse Practitioner and/or	ath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	o the vithin o the omple	Mec	29b. Signature ang titige of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F > F 0		* Africa CNAP	R149792	4/30/2009
	V		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1199
	2		JACKIE JONES CRNP 2300 DULANEY VA	LLEY RD. TIMONIUM	, MD 21093

DHMH 17 Rev 1/2001

3:00 а.ш.

APRIL 30, 2009

MARGARET POLEK

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #2, perMD g891 5///09 TT.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Dea**28**Month 27 Day 2009 Year 1. Decedent's Name (First, Middle, Last) 3. Time of Death Aprit **Physician** 9:35 A Mary Dorothy Panzarella /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Gilchrist Towson 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 10/8/1918 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min 1 M 2 X F 215-50-0456 Mary Tand 90 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a, State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas pepartment of Health and Mental Hygiene. Important: If Hean 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modeal Examine must be notified a MD Baltimore Towson 1 ☐ Yes 2 V No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates Specify Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hairdresser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental H tem 27 Is marked oth Be Rosario Ciurca Rosaria Agro 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9341 Farewell Road Columbia, Maryland 21045 Gloria Roe / Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/2/2009 Timonium, Maryland Dulaney Valley Mem. 21. Signature of Juneral Service License 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) acs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): Box 68760, physician the buria Physician/Medical as attending IF FEMALE use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? P 5 Other (specify) P.O. I the a be detached 9 Unknown 9 Unknowi signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes, 2 ☐No Physiclan; Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSOCO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 0930M 5 Pending investigation 1 Natural s after death.
I Director: Af UNWITNESSED Fall 1 □Yes 2 No 2 Accident APRIL 12 2009 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Assisted IVING Faculty

1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours a To the Funeral C filled 29a. Certifier Medical completely (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

Year

MAY 01

ORIGINAL

ves MO

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03427 State of Maryland / Department of Health and Mental Hygiene Kwame Mandella Parker Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 28, 2009 2004 hrs Medical Examiner Kwame Mandella Parker 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours PA 198-74-6895 Country) Director 1 X M 2 F 18 7-17-90 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State any 1 X Yes 2 No MD Frederick Frederick or 28a-f show s 23a or 28a-f shove e notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 231 W. South Street 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items Armed Forces? 2 Married 1 X Never Married Yes 2 X No Specify: black Yes 2XX No specify. f Yes, Give Yee Divorced narked other than "natural", event, the Medical Examiner Widowed 4 \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours in nent of Health and Mental Itygiene. 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+ Elementary/Secondary (0-12) unemployed none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Parker Glendola Mills marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is VA23518 8422 Tidewater Rd.#12 Norfolk, Glendola Parker/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Levittown,PA nent Bucks County Crem. 5-6-2009 Other Specify Donation 5 22. Name and Address of Facility Baltimore, MD Charisse Woods Fun.Sv.3307 21. Signature of Funeral Service Licensee MO1358 Mondawmin Av Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical a Gunshot Wound of Neck and Head Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine

and - transit attending physician or use as the burial The law requires that the death certificate be Box 68760 Ö σ. has certificate

Division of Vital Records, Hospital or Attending Physician: 24 hours after death. this After

Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes Nο Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other 4 examiner? Residence 6 Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 1 Yes ဥ 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Apr 28, 2009 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot self

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a)

Pending

Investigation

Could not be

determined

O.C.M.E.

29c. License number

Yes 2 V No

29d. Date signed (Month, Day, Year) April 29, 2009

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 223 West South Street, Frederick, MD

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

Redistrar's Signature

(Specify) Single Family

and manner stated

31. Date filed (Month, Day, Year) State Registrar

Medical

Natural

3 V Suicide

Accident

Homicide 29a. Certifier 1

29b. Signature and title of certifier

2

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1940 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

THELMA RYAN

	1	For State Registrar		se Type o Per FH G8 State		Ce	rtificate	of E	Death			Reg. No.		1707
hysici	an	1. Decedent's Nam		(e, Last) RYAN -							2. Date of D Month	Day Day	Year	3. Time of De
/Medic Examir		4a. Facility Name (i		-	number)		4b. City, 7 Be1		Location	of Death		4c.	County of De Harfo	
uneral irector		5. Social Security N		6. Sex 1 ☐ M 2 ☐ F		s. last birthday, Yrs.) If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B	Sirth Year)	9. B	irthplace (State or Fo Country) MD
-		Usual Residence o			100 (City, Town or L								10d. Inside City L
a or 28a-f show be notified at	ō	10a. State MD	10b. County	arford	100.	Bel A								1 □ Yes 2
28a-f	Director	10e. Street and Nu		arroru		DET 1	10f. Zip	Code				10g. Cit	izen of What (Country?
23a or		514 Red	Pump 1	Rd				014_				US		
ems	Funerai	11. Marital Status		12. Was D Armed	ecedent Ever in Forces?	U.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cubar	spanic Or n, Mexica	rigin? (Sp ın, Puerto	ecify Yes or N Rican, etc.)	NO-	14. Race - An Black, Wh	nerican Indian, nite, etc.
al', or items 23a Examinations	by Fu	1 Never Marr 3 XWidowed	_	rried 1 □ Ye If Yes, Year o	s 2 X No Give Dates:		1 ☐ Yes 2	K No	Specify	r:		:	Specify: W	hite
"natural", idical Ex	ted		15. Deceder	nt's Education		16a. Dece	edent's Usua e kind of wor	I Occupa	ition	st of work	ina	16b. K	ind of Busines	ss/Industry
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d other than	S	17. Father's Name	/First Middle	/ act)		Sale	S		18. Moth	ner's Nam	e (First, Mida			illinery
ed of) Be	Charles									Myers			
mark	P _C	19a. Informant's N	lame/Relation	ship (Type, Print)		19b. Mail	ing Address	(Street a	ind Numb	er or Rur	al Route Nun	nber, City	or Town, State	, Zip Code)
27 is ertra		Patrici	a Fox	(Daughte		The second section is a second	Red P	_	Rd		Air, M			
if item		20a. Method of Dis		3 □Removal fro		. Place of Disp cemetery, cre	osition (Nan ematory or o	ne of ther plac			Date			or Town, State
tant: i		`4 □Donation	5 Other (S	Specify)	Ва	ayview			1		2009	Ba1	timore	, MD
Department of Healin and Mental ryglery important: if item 27 is marked other th. any injury or other traumatic event, Ing. 0068.		21. Signature of F	uneral Service	Licensee	>		22. Name an			Scn	imunek	Fune	eral Ho Air, MD	me of Bel
		23a. Part1. Enter	the disease, o	or complications the	at caused the de	eath. Do not er	nter the mod	e of dyin	g, such a	s cardiac	or respiratory	arrest,	111 6 111	Approximate Interval Betwe
ysician		Immediate Cause disease or conditi	(Final		HRONIC	RE	NAL	FA	ILV	RE	4			Onset and De
ledical		resulting in death)		a	to (or as a cons	-								1042
aminer	_	Sequentially list co	onditions,	b	to (or as a cons	editence off.								
nsit	Examiner	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of that initiated event	erlying r injury	1 .4	15111									64
an and rial-transii	Еха	resulting in death)	Last	C. Due	to (or as a cons	equence of):								
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attending physicla for use as the bur	by Physician/Medical	IF FEMALE:		23c If yes	outcome of pre	nancy							23d. Date of	delivery
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gned be det	by P	Part II. Other sign	ificant condit	ions contributing t	o death but not i	resulting in the	underlying c	ause giv	en in Parl	t I.			,	e to the cause of dea Probably 4 □Un
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has b	mple										24a. W au	ras an utopsy erformed?	death	autopsy findings av to completion of cau 1?
certificate rector, pag		05 11/1-1-1-1-1		al .					GC Die	as of Dag	th (Check on		o 1 🗆 Y	res 2□ No
s certi	To Be	25. Was case reference examiner?		Hospital:	☐ Inpatient 2	ER/Outpati	ent 3 DC	Oth Oth				4	6 □Other (S	Specify)
n. After this funeral di	T:U	27. Manne if Dea	ath	28a. D	ate of Injury fonth, Day Year	28b. Time	of 2	8c. Injur Wor	y at				ury occurred	
death. c tor : Aft the fur	atic	1 atural 2 Accident	5 Pend inves 6 Could	tigation			М	1 🗆	Yes 2[□No	204 1	- (0	and Al	Pural Paula Must
in by	Certification:	3 Suicide 4 Homicide	datas	mined 200. F	ace of Injury - A uilding, etc. (Spe	t home, farm, s ecify)	street, factor	y, office				n (Street a Town, Sta		r Rural Route Numbe
ours a		29a. Certifier	1 Certify	ing Physicien: To	the best of my	knowledge, de	ath occurred	at the tir	ne, date	and place	, and due to t	the cause(s) and manne	r as stated.
e Fur	Medical	(Check only one)	2 Medica	I Examiner: On th	e basis of exam nanner stated.	ination and/or	investigation	, in my o	pinion, d	eath occu	rred at the tin	ne, date a	nd place, and	due to the cause(s)
within 24 hours a To the Funeral I completely filled	Me	29b. Signatule ag	Chitle of certification	ier MD.			29		e nu <i>m</i> be			29d. D	ate signed (M	lonth, Day, Year)
											1:0:000	06	111	21220
14		30. Name and add	dress of perso	n who completed of	ause of death (Item 23a) Typ	O'Print)	BL	- D	BA	LTIMO	KE	MD.	-1239.
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AIM 2000 oner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Severna Park

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Anne Arundel Co. Heartlands Assisted Living Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Yrs. 5. 1927 Massachusetts Director 028-20-3361 81 Oct. Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10h County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hyglene.
sint: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, ith "Molecil Exp. in a front ten contility or other traumatic event, ith "Molecil Exp. in a front ten contility at 1 Yes 2 No Director Pasadena Maryland Anne Arundel Co. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 United States 7652 Water Oak Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1127]Yes 2∐ No IfYes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 √ Widowed 4 ☐ Divorced Year or Dates: WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Gas & Electric Co. Systems Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corinne Marmen Alfred Roberge ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 7652 Water Oak Point Road Mr. Michael J. Roberge / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages t Department of H Important: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery | 05/12/2009 | Crownsville, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service Singleton Funeral & Cremation Services PA; 2nd Ave. SW Glen Burnie, MD 21061 M01121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria The law requires that the death certificate be-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 🖪 No 1 ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) MUTEL Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

State Registrar 30. Name and address of person who completed days of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	State of Maryland / Department of Health and Me Certificate of Death		.No2009 14046
	Physici		1. Becode the National Control of the Control of th	Date of Death Month	Day Year 8:48A M
	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	77 2	4c. County of Death
	Funeral Director		213-52-5437 60 Yrs. J	Date of Birth (Month, Day, Youly 24)	9. Birthplace (State or Foreign Country) 1948 Nor th Caroli
	how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the Mar 28a-f s	recto	MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code	10g	1 ☐ Yes 2 No
	ath with 23a or	Funeral Director	1807 Wilhelm Avenue 21237		USA
-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examinet must be redified at	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② ☒ No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-0	in 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16	b. Kind of Business/Industry Construction
212	be filed within 72 ho htal Hygiene. d other than "natu event, the "hocie"		Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First)	First Middle Ma	iden Surname)
land		To Be	77. Tallot o Harris (Fines) ===-9	a Boge:	
Mary	12 shout and No is and Its man	7	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Informant's Name/Relationship (Type. Print) 19c. Mailing Address (Street and Number or Rural Informant's Name/Relationship (Type. Print)		
Baltimore, Maryland 21215	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 4/27	te 20	altimore MD
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility 300 Connelly Funeral	Home	of Essex 21221
	Tificate be executed By physician and as the burial-transit as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):	Failure	it, Approximate Interval Between Onset and Death
O. Box		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) □ □ Unknown	-	23d. Date of delivery Month Day Year
o.	w requires that the de s been signed by the s should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
of Vital Records,	The la ate ha: page 2	Completed	Depression	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 ☒ No
Vit	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home) ice 6 ☐Other (Specify)
Division of	fing Afte fune	Certification: T	27 Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident State of Injury 28b. Time of Injury Work? 1 Year) M 1 Yes 2 No	8d. Describe how 8f. Location (Stre City or Town,	eet and Number or Rural Route Number,
ח	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) Additional Control of the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place, at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and place at 2 Medical Examiner: On the Dest of my knowledge, death occurred at the time, date and date	and due to the car ad at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
10	To the within 2 To the complex	Me	29b. Signature and title of certifier D21846	290	d. Date signed (Month, Day, Year) 4/25/09
				altimor	, MD 21237
	Sta Regist	ite ar	31. Date filed (Month, Day Year) 200 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** George William Riser, Jr. 1805 PM APRIL 25 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sep • 10, Year 1944 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months West Virginia Days Hours 1**X** M 2□ F 64 212-42-3088 Yrs. Director Usual Residence of Decedent 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at 10c. City, Town or Location 10h. County Y Yes 2 □ No Baltimore N/A Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 United States 4002 Walrad Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 □ Yes 2 XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy May Grimm George William Riser, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1247 Haverhill Road, Baltimore, MD 21229

ce of Disposition (Name of Date 20c. Location - City or Town, State George W. Riser, III Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 29a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4-29-2009 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify)
Significant of Operal Service Leense 4 Donation Ambrose Funeral Home, Inc. 22 Item e and Address of Facility 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SQUAMOUS LUNG CARCINOMA UNKNOWN **Physician** CELL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CUTE REST DISTRESS SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner EPTIC SHOCK Due to (or as a consequence of) signed by the attending physician The law requires that the death certificate be NCYTOPENIA 2 WEEKS Completed by Physician/Medical as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Year Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4/0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RRHOSIS EmpyEM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 1 No 1 ☐ Yes in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Vital Physician: of Division ō within 24 hours a To the Funeral C the

Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

HAFSA KHAN, ST. AGNES

acks

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

HOPITAL, 900 CATON ARE, BALTIMORE, MD. 21229

P20659

29d. Date signed (Month, Day, Year)

APRIL 25th 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G891, 5/21/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) APU L Physician 22 2009 Aurora Robertin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Baltimore / Washington Medical Cntr. Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2/3/1908 5. Social Security Number 6. Sex **Funeral** Months Days Min 28 1 □ M 2 🔀 F Hours Puerto Rico -3996 Director 101 Usual Residence of Decedent 10d. Inside City Limits Maryland 10a. State 10h County 10c. City, Town or Location show event, the Medical Examiner must be notified at トレット・レート DE かのりは Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Director 28a-f Fairview Cupey San Juan with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or USA 00926 C - 36Street #13 Funeral death v 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status 1 □ Never Married 2 □ Married 1⊠Yes 2 No Specify. Specify If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced White Puerto Rican Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, It. Mean injury or other traumatic event, It. Means injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) <u>Teacher</u> Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAria Rivera Pedro Robertin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Azosta # 97 Caguas, Puerto Rico Jose Monge / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/28/09 San Juan, Puerto Rico 4 Donation 5 ☐ Other (Specify) National Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licer Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death dications that caused the one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or con-shock, or heart failure. List only Immediate Cause (Final nenmonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U certifit of Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 □Yes 2 □ No after death.

Director: Ald in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 of person who completed cause of death (Item 23a) (Type, Print) Name and addres M. 31. Date filed (Month, Day, Year)

NY - 1 2009 gregun State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nq. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 8:45 P.M 30, 2009 Aileen Stapleton April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) May 30, 1964 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Baltimore, MD. **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 44 Director 215-94-7992 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Experiment must be rediffed at 1 ☐ Yes 2X No Director Maryland Nottingham Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21236 Apt.303 9502 Perry Hall Blvd. Funera Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 🏖 ☐No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) A&G Management Property Manager th and Mental Hygie 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland Maurice Locklear JoAnn Haynie ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Pages 1 and 2 9502 Midaro Court Nottingham, Maryland 21236 Mrs. Tosha D. Rider (Niece) May 02, 2009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A , 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Interthe disease, or implications that caused the death. or heart failure. List only one cause on each line. Immediate Cause (Final Bladder Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, physician certificate be Physician/Medical attending IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months?

1 Yes 2 No
9 Unknown Ď 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗆 No 2 N 1 ☐ Yes certificate 1 ☐ Yes Attending Physician: completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28c. Injury at Work? Certification: After Injury (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Hospital or Attendi 24 hours after death. Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu re and title of certifier 7500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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CHAPLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 14050 Reg. NaZ U () S Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 2009 05:26A M Virginia Lee Spindler 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE N/A ST. AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 1 □ M 2 💆 F Months Days Kentucky 71 215-34-6901 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 XYes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 800 S. Beechfield Road 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Specify: White 1 ☐ Yes 2 📉 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Barnett Nellie Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 800 S. Beechfield Rd., Baltimore, MD 21229 Charles Spindler - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Gremation 3 Removal from State 4-29-2009 Loudon Park Cemetery Baltimore, MD 5 ☐Other (Specify) Ambrose Funeral Home, eral Service Lidensee - Name and Address of Facility 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENCEPHALOPATHY Immediate Cause (Final (HI POXIC / ANOXIC disease or condition resulting in death) Due to (or as a consequence of): 20 days SPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy $1 \square \text{Live birth} \quad 2 \square \text{ Fetal death}$ 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Year 5 Other (specify) 9 Unknown

/Medical Examiner burial-tran 68760, the Box o ď PINDUER Records, certificate of Vital

or Attending Physiclan; The law requires that the death certificate be executed

ate has been signed by the attending page 2 should be detached for use as within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examine

Be Completed by Physician/Medical

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

Part II. Other significant conditions control O i ARGETES MEL	ributing to death but not resulting in the underlying $\Box \uparrow \cup \dot \Box$	cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Tes 2 PN 3 Probably 4 Unknown
HYPERTENSION COROHARY AND	TERY DISEASE.		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Dea	h (Check only one)
examiner?	ospital: 11 ppatient 2 ☐ ER/Outpatient 3 ☐ E	OOA Other: 4 In Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death ↑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ician: To the best of my knowledge, death occurre er: On the basis of examination and/or investigation and manner stated.		, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

29c. License number

NPI

1730335878.

BALTIMORE . ND 21229

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (M

MOPALES

900 CATON AVENUE

e and addless of porson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 per Fh 9891 5/18/09 TT State of Maryland / Department of Health and Mental Hygiene 9 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Richard Lorenzo Sembly, Sr. 28, 2009 6:00 A. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville 601 W. Seminary Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 213-14-9188 **№** M 2 🗆 F 1922 Maey land 24, **Director** 87 Mar. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 21093 USA 601 W. Seminary Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ NoWW 2 If Yes, Give Year or Dates: hours after Special Black 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify: ģ XXWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medicone. & P Telephone Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Jordan Edward Sembly ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) W. Seminary Ave Lutherville, Maryland Jarvis Garrett/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses <u>5240 Reisterstown Road Baltimore,Md21215</u> Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part . Enter the disease shock, or heart failure. 1 Immediate Cause (Final disease or condition resulting in death) lent **Physician** /Medical Due to (or as a consequence of): **Examiner** DNaeskve Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be execute sician and burial-trans Due to (or as a consequence of): physician a s the burial-Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown atter for u 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this : After thi tuneral of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 MedicalExaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and ti 29d. Date signed (Month, Day, Year) Attending 30, 2009

State Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 1 2009

M.D.

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complete cause of death (Item 23a) (Type, Print)

3512

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Virginia Marie Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale
If Under 1 Year I If Under 24 Hrs. tranklin Hospital Center timore rillare 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours 11/15/1934 1 □ M 2 🗙 F Maryland 74 219-30-6464 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is mar ed other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r 324 Sassafras Road 21221 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2XMMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elder Care Caregiver Pages 1 and 2 shou d be filed venent of Health and Mental Hygicant: I item 27 is man ed other: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Alexander Bevans Mildred E. Peyton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: I item 27 is any injury or other training. Archie Kendall Smith, Jr. (Son) 324 Sassafras Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gard. 05/02/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fu and Service censee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final dise or condition read gin death) Resuratory F Due to (or s a consequence of): **Physician** Failure /Medical Examiner Metastlic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Breast Cancer physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 ☐ Unknown vate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) PP Medical to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 04/30/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md 21237 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 04 30 2009 Sidik TAVERalli /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 1 Year | If Under 24 Hrs. If Unde 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🗖 M 2 🗆 F 214-76-6410 60 1949 East **Director** 18 Africa Jan Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the mounted Examiner must be notified at MD HARFORD 1 ☐ Yes 2 No Havre De Grace Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 109 N. Earlton Road 21078 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ∐Yes 2xX No Yes, Give 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Indian 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th NA Car Dealers Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be h and Mental 7 is marked o Ayub Sidik Halimabai Kasam Dada ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau Nayim Sadik - Son 109 N. Earlton Rd Havre DeGrace, MD 21078 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ₭ Burial 2 Cremation 3 Removal from State Randallstown, MD King Memorial Park May 1, 2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West 21215 Baltimore, MD 23a. Part I. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart rature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin **Physician** Myocardial disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oncletiti Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown this certificate has been srai director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funerai 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation (Month, Day, Year) 1 Natural 24 hours after death. e Funeral Director: Aft pletely filled in by the fur 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

within 2

State Registrar

29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print)

ZZ 32. Registrar's Signatu

29c. License number

1003019621

29d. Date signed (Month, Day, Year)

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/Me Exan	dical niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	-	4c. County of Death Anne Arundel	- F
Funer		625 Fernhill Road 5. Social Security Number 6. Sex 1		8. Date of Birth (Month Day, Nov. 8,	9. Birthplace (Sta Country) Maryland	te or Foreign
Directo	or	213–26–6923 // /9 Yrs. Usual Residence of Decedent 10a. State	ocation			e City Limits
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Maryland 21215-0036 to 2 should be filed within 72 hours afte the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Modical Event traumatic event	T G	John H. Eisemaidt	Virgini iling Address (Street and Number or Ru			
2 p±0=		Robert L. Goolsby (son) 625	Fernhill Road, B	altimore,	Maryland 21226	
Baltimore, bermit. Pages 1 an Department of Hea Important: If item 2 any Injury or other		4 Donation 5 Other Specify) Bayview	020	1	altimore, Mary	
Balti permit. Departr Importa any Inja	once.	21. Signature of Funer of Strvice Licensee	22 Name and Address of Facility McCully—Polyniak F 3204 Mountain Road	uneral Ho , Pasaden		
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Division of Vital Ra To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	7	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 29a. Certifier 2 Certifying Physician: To the best of my knowledge, de (Check only one) and manner stated.	eath occurred at the time, date and plac r investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as stated. te and place, and due to the cau	use(s)
To the		29b. Signature and title of certifier	29c. License number D06059	,	d. Date signed (Month, Day, Ye	ar)
)		30. Name and address of person who completed cause of death (Item 23a) (Type		ICA (14.2103	5
	State istra		es		7100	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** A^{M} April 27 2009 3:20 Alice Mae Skeals /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Manor Care Dulaney Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖼 F 96 New York 215-40-4786 August 18, 1912 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐Yes 2 No Director Maryland Baltimore Towson notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with a or U.S.A. 21204 111 West Road 23a r than "natural", or items 23s the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: Specify. White ò 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Apartment Complex Rental Agent h and Mental Hygien 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Brown Elmer E. Neilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 2305 Foxley Road, Timonium, Maryland 21093 Virginia Hellman / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-30-2009 Towson, Maryland 21. Signatur Juneral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oronar **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transi Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical as the signed by the attending d be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 2√ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an autopsy 1☐ Yes 2 **20**00 Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident af er death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide | Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the rel #209 Transmetrial 29d. Date signed (Month, Day, Year)

rel #209 Transmetrial 21093 29b. Signature and title of certifier 3 mpleted cause of death (item 23a) (Type, Print) 30. Name and address of person who

State Registrar 31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) STORKE A Pri Year **Physician** BARBARA 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIHOR North West HOSPITAL ANDALLSTOWN | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 😿 F Yrs. 61 **Director** 220-76-3429 March 16. 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 2 should be filed within 72 moves 1 and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo Randallstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 5412 Old Court Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ₩ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disability <u>Dependent</u> 0 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any linjury or other traumatic event once. Be Willner Evelyn C. S. Storke Wilbur ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> 10 N. Calvert St. Ste 620 Baltimore, Md. 21202</u> <u>Arthur Drager/ Attorney</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 5-1-09 Baltimo

22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. Baltimore, Md. 21. Signature of Funaral Service Vicenses 1050 York Rd. Towson, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): **Examiner** NEU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 1 ☐ Yes 2 ☑ No 2 210 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

5401 Old Court 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

D65843

Road , Randallstown , HD

29d. Date signed (Month, Day, Year)

1920 Rock Spring Road Forest Hill MD 21050 To the Hospital or Attending Physician: hours after death. Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number April 25, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date file 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death WEISS Year 07 0 8454 **Physician** REY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Tate Hospice House Linthicum Anne Arundel Under 1 Year | If Under 24 Hrs. onths Days Hours Min. 8. Date of Birth

JUN 4 1941 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1. M 2□ F New York 570-54-1620 67 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Director MD Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21012 218 Baybourne Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Nyes 2 □ No If Yes, Give Year or Dates: **Vietnan** 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of and Mental Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Defense Intelligence Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Brasman Morris Weiss မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Linda L. Bothe - wife 218 Baybourne Drive, Arnold, MD 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 04/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses Steven H Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera House Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in The CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d Date signed (Month, Day, Year) Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

con viol completed cause of death (Item,28a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** GERRU 1037 AM 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAUTIMURE-HOPKINS CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Austria 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/29/19 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**№** 2□ F 8 13-16-464 8 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20. 1-1 any Injury or other traumatic event. If I was a marked other than "natural" or items 23a or 20. 1-1 once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2120 V)OPPA 12. Was Decedent Ever in U.S. Armed Forces? 1 Xves 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) swimming pool Elementary/Secondary (0-12) College (1-4or 5+) self employed construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bruno Weiss Dora Berger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Weiss/spouse 1055 W. Joppa Road #714 Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Epneral Service Licensee Ronald S. Wade 655 W. Baltimore Street un Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and 9 use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) \$2. Registrar's Signature

29b. Signature and sitle of certifie

29c. License number

1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gary Wayne Webb April 2009 8:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8393 Knighton Court Union Bridge Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 XM 2 □ F Hours Min Yrs Director 216-60-7832 56 May 23, 1952 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrainer must be notified at ence. 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Maryland Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8393 Knighton Court Funeral 21791 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Be Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 self-employed contractor home improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Willis F. Webb Ida Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa M. Webb/ wife 8393 Knighton Ct. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lukes Cemetery 4/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Feagaville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home amorine 1 11802 Liberty Rd. Libertytown, MD 21762 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HTHEVOSCLEROI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed caluse of death (Item 23a) 10 V 31. Date filed (Month, Day, Year, 32. Registrar Signat State 2009 MAY 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09-03314 Chris Me

OCME	カッ	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician \ /Medical	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evect, the Medical Examiner, must be notified at once.
		Medical Certification: To Be Completed by Physician/Medical Examiner		To Be Completed by Funeral Director

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s Woods		1- For State	d / Department <i>Certificate</i>	of Health and Menta of Death		2009	1406
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)	nei	4a. Facility Name (if not institution, give street and number	V 0000	4b. City, Town, or Location of I	April 25, 26	4c. County of Death	
´		3117 Brighton Street	Ago (In use loot highbolou)	Baltimore	Odline To Date of Rich	N/A	hplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. 7. 7	Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours Yrs.	Min. () 7-2		untry)
y		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Loc	action .	070	1_0777	10d. Inside City Limits
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0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once.	Director	10e. Street and Number	Ct.	10f. Zip Code	, 10	g. Citizen of What Cour	ntry?
with the	ō	3/17 Bng6 ton 11. Marital Status 12. Was Decede	ent Ever in U.S. 13. \	Was Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Americ	can Indian, Black,
or item	Funer	1 Never Married 2 Married Armed Force 1 Yes		f Yes, specify Cuban, Mexican, P		White, etc.	1/2-16
urs after tural", aminer	ğ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or		Yes 2 No specify: lent's Usual Occupation (Give kin		Specify: >	ndustry
36 n 72 ho nan "na lieal Ex	plete	Elementary/Secondary (0-12) College (1-4 o	or 5+) during	most of working life. DO NOT us	se retired)	NOODO	COACH
215-0036 be filed within 75 ntal Hygiene. rked other than cot, the Medical	Completed	17. Father's Name (First, Middle, Last)		18.Mother's	Name (First, Middle, M	MOTOR	Coacri
2121; uld be fill Mental H marked c eveot,	Be	19a, Informant's Name/Relationship (Type, Print)	10h Mai	ling Address (Street and Number	ns or Dural Doute Num	her City or Town State	Zin Code)
MD 2 d 2 shoul th and N 1 27 is m	70	0 1 1	500 430		cut Are A	. //	to, md, 2122g
- E E E		20a. Method of Disposition 1 Burial A Cremation 3 Removal from		osition (Name of cemetery, other place)	Date	20c. Location - City or	Town, State
Baltimore bermit. Pages 1: Department of H Important: If it		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Metro	Crematory C. Name and Address of Fadlity	270 5	Capasi	Pan.
Baltii permit. Departm Imports injury o		Sory 1. Want	- 6	ang P. marc	ht. T. 1	Salto, n	di 21229
Physician / /Medical		23a. Party The disease, or complications that cause failure. List only one cause on each line.			diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Typertensive and pue to (or as a condition resulting in death)		diovascular Disease			
	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cor	nsequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a cor	nsequence of):				
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	edi	IF FEMALE: 23c. If yes, outc	come of pregnancy			23d. Date of delivery	L .
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	Physician/M	23b. Was decedent pregnant in the past 12 months?	at time of death	Fetal death 3 Ectopic p Other (Specify)	regnancy	Month D	ay Year
O. Boy at the death I by the att tached for	hysi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de		e underlying cause given in Part	1 230 Did to	pacco use contribute to	the cause of death?
S that is the general edge of the degree of	ð	Clinical history of prostate cancer	aur but not resulting in the	e underlying cause given in Fait	1 Yes		
cords, law requir has been s	Completed				24a. Was a autops	sy prior to c	topsy findings available ompletion of cause of
tal Reccian: The lar	Com					med? death? 2 ✔ No 1 Ye	s 2 No
Vital ysician: his certi	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpa	itient 2 ER/Outpatie	26.Place of Death (C ent 3 DOA Other,		Residence 6 🗸 Other	Scene
Division of Vital Records, lat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death 28a. Date of Ir (Month, Day		of Injury 28c. Injury at Work?	11.	ow injury occurred	
Visior or Attend fler death Director: in by the	fication	2 Accident Investigation	Injury - At home, farm, st	reet, factory, office building, etc.		treet and Number or Rui	ral Route Number, City
Div spital o	Certific	4 Homicide determined (Specify)			or Town, St	ate)	
To the Ho within 24 1 To the Fu completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: In the best of examiner: In the basis of examiner:	xamination and/or investig				
Y ≥ E S	Me	29b. Signature and title of certifier	u	29c. License number	-	29d. Date signed (Mon	th, Day, Year)
31		30. Name and address of person who completed cause o	f death (Item 23a)	O.C.M.E.		April 29, 2009	
OCME		Mary G. Ripple MD. Deputy Chief Med	dical Examiner 1	11 Penn Street, Baltimor	e, MD 21201		
St Regist	tate trar	31. Date filed (Month, Day, Year) - 32 Regist	trar's Signature	Not			
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:30 P.M April avid Lugene Wynn 2009 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore of B. Itimore Singi 10 me C If Under 24 Hrs Hospital 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Mary land Days Min 1 M 2 □ F 217-76-9739 9 May Yrs. **Director** 31, 1959 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is merked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 🗹 No MD Wood laun, Mar Director mos 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5509 Oak Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: Black þ 3 Widowed 4 Divorced Completed Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day CURE Maintenance Engineer Known as: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCOTT hardette Kobert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1337 Winstan Ave Balto ma 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mill, MD Forest May 1,2004 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Romard a Mirryson Furence Ceruce ald Paga md 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 9 days Lichemic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes ours after death,
eral Director: After this certific
filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 🔲 Inpatient 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours a

To the Funeral C The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steele W. Belvedere Baltimore, MO 21215

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

2009

-1

2401

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:00 AM Zawadzki Darlene Joann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Union Memorial Hospital 8. Date of Birth 9. Birthplace (State or Foreign Aug. 21, 1958 Mary Land If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 ☐ ¥F Months Days Hours 50 216-78-8062 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Examiner must be notified at 1 Yes 2 □ No Director Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 21218 926 Homestead Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 2yrs f Health and Mental Hygiene. Item 27 Is marked other than Johns Hopkins Computer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley M. Zawadzki Stella M. Sydlik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley Zawadzki (brother) 1415 Woodridge Manor Road Fallston, Md21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-2-2009 Baltimore, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21222 200 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** year 6 00 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical After this certificate has been signed by the attending I tuneral director, page 2 should be detached for use as IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □NO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 □Yes 2 □No or Attending Physician; 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dimpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐Yes 2 ☐No within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital

State Registrar

2

Medical

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

MARMAMSAGED-ZOIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

University 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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			Registrar/ Decedent's Nam		4/17/09,BW,1	<u> </u>	- Certii		Jeani	2.	Date of De	Reg. No.	2005	3. Time of Death
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	e Hos 1 24 h e Fur letely	Medical	(Check only one)	2 ☐ Medical Exa	miner: On the basis of and manner sta	examination a	and/or investi	gation, in my op	inion, death	h occurred	at the time,	date and	place, and due to	the cause(s)
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			30. Name and addre	ess of person who	completed cause of de	eath (Item 23a) (Type, Print							
			Raman R. 31. Date filed (Mont.		, 3503 Perry		Suite I	, Mt. Rat	inier,	Maryla	nd 207.	12		
	Sta Registr	C	AP		109 Linux	r's Signature	back	1						

Michael Asghenbrenner 09-03257

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	30	. Name and address	ss of person	who completed cau	se of death (It	tem 23a)						
(ba)		Pamela E. Si	outhall, N		Medical E		1 Penn Street	t, Baltimore, I	MD 21201			
State		. Date filed (Mont)	PRYZ		egistrar's Sign	nature /						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4: 05 AM Ayers, Jr. 04 15 -2009 Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner W. comico Salisbury the Lake Coastal Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5-31-1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Months Delaware 220-28-1506 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Mcdical Examinar must be notified at 1 ☐ Yes 2X No Director Wicomico Hebron MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21830 USA 100 Barbara Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify: <u>∂</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ С. Ayers, Sr. Mary Cicatelli Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any Injury or other trau once. 100 Barbara Avenue, Hebron, MD 21830 <u>Norma Ayers - Wife</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \$pringhill Memory Gds. 4-18-2009 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Fune al Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one figns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage Physician Disease Chronic /Medical Due to (or as a consequence of): Examiner percapne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: Certification: To 1 ☐ Yes 2 [N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation Matural Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely within 2. and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number me and ress of person who completed caus of death (Item 23a) (Type, Print) att State

DHMH 17 Rev 1/2001

Registrar

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98	after or Iter	y Fur	1 Never Marri	_	Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give	No		fYes, specify Cub I □Yes 2 □ X No		rto Rican, etc.)		Black, White, e	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Ignature of Fu		isee A		22	Name and Addre	ess of Facility				
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	Examir	er	4a. Facility Name (If not institution Solomons Nursi	_	m <i>ber)</i>		Solo		Location o	or Death		1	County of De Calvert		
	Funeral Director		5. Social Security Number 577–24–8516	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	91919	9. B	Birthplace Country)	State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d.	Inside City Limits
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336	urs after ar", or ite	b	1 ☐ Never Married 2 ☐ Mai 3 ☐ XWidowed 4 ☐ Divorce	If Vac G	2 XNo ive		fYes,spec 1⊡Yes 2	•	n, Mexicar Specify:	n, Puerto	Rican, etc.)		Black, Wh Specify:	Whi	te
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21215-0036	within liene, r than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sales	cles	e retired)		v	Dept	ment S	Stor	е
and 2	d be filed ental Hyg ked other c event,	To Be C	17. Father's Name (First, Middle, William Taylor								(First, Middle Villett		Surname)		
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event her mat by notified at Once.	Ĕ	19a. Informant's Name/Relations Patrick Reese		n)	19b. Maifir 732	g Address Plante	(Street a	and Numbe Wharf	er or Rur Rd	al Route Numi Lusby ,	ber City of	r Town, State 20657	e, Zip Co	de)
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Balti	permit. Departm Importa any inju		21. Signature of Funeral Service	Licensee	ry Goff						Funer and BI	al Ho	ome Cal	lver MD	t ₂₀₇₃₆ .
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	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Medical (29a. Certifier (Check only one) Certifyii 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	owledge, death ation and/or in	occurred a restigation,	it the tin	ne, date an pinion, dea	id place, th occurr	and due to the red at the time	e cause(s) , date and	and manner place, and d	as state	d. e cause(s)
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7.01			30. Name and address of person Dr. Gwyneth B				tal D	rive	Sui	te#	310 Pri	ince	Freder	ick	MD 20678
U.	Sta Registra	_	31. Date filed (Month, Day, Year)		legistra#s Signa	ature	-		0						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** p^{M} April 2009 7:20 Richard Block Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gaithersburg Montgomery Wilson Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min. 1K M 2 □ F 8/1/1914 94 Director 216-44-4479 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1⊈Yes 2□No "natural", or items 23a or 28a-f sl dical Examiner must be notified Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3700 International Drive #340 20906 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give WWII Year or Dates: 1 → Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Interstate Commerce College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) filed withir Hygiene. Commission 5+ Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Cohn Richard Block Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any Injury or other trau Stanley Friedman Nephew PO Box 351441 West Minster CO 80035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 4/14/09 Iselin, NJ 4 Donation 5 Other (Specify) 22. Name and Address of FacilityEdward Sagel Funeral Direction Inc 21. Signature of Funeral S 1091 Rockville Pike Rockville MD 20852 HONG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) centicute **Physician** /Medical Due to (or as a consequence of): Examiner Trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mp Due to (or as a consequence of be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) n signed by the a 9 Unknown 23e. Did tobacco use confribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown ate has been si page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed there teneful mary descent building milling 2 🖃 No 2 / Place of Death (Check only one) Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred funeral 1 □ Natural 5 Pending Freek 1 ☐ Yes 2 ☑ No investigation 2 Accident 28e. Place of hjury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Bural Route Number of City or Town, State) 370 / Lanton DI 4 Homicide

P.O. 1 Division or Vital Records,

or Attending Physician: death. Director: in by within 24 hours a To the Funeral I To the Hospital

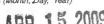
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

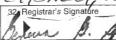
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)





and manner stated.

Men Cuity Assthring Silver Spring mo 20906

04/15

29d. Date signed (Month. Dav. Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pice, and due to the suse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:50 am 2009 Harold Bleicher 15 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director October 23, 1915 District of Columbia 578-03-2236 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or dical Examiner must be i 1417 Castle Cliff Place 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 15d Yes 2 □ No if Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medica Examiner one. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ò Specify 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Lawyer Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Bleicher ျှ Eva Spivak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melissa Albaugh - Daughter 1417 Castle Cliff Place, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 04/16/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the sisea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure ist only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner DEMENTA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examine the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Within 24 hours a

To the Funeral I

completely filled

State Registrar 29b. Signature and title of certifier

S.M.NAYAR 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

DHMH 17 Rev 1/2001

29c. License number

AVE

D-17874

29d. Date signed (Month, Day, Year)

MD 20722

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month April 1. Decedent's Name (First, Middle, Last) 14 2009

Months Days

7. Age (In yrs. last birthday)

76

Yrs.

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Min.

04:20 AM

9. Birthplace (State or Foreign Country)
Maryland

4c. County of Death

Cecil

8. Date of Birth (Month, Day, Year) March 10,1933

Physician /Medical

1 - For State Registrar

Eddie L. Basham 4a. Facility Name (If not institution, give street and number) **Examiner** Laurelwood Nursing Center 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□ F 213-30-8872 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Modeni Eventine Intertal Eventine Intertal Foreign at any injury or other traumatic event, I'm Modeni Eventine Intertal Eventine Internation Intertal Eventine Intertal Events Intertal Eve Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, BASHAM EDDIE

	Usual Residence of Decedent								10.1.1.1.00.11.0	
_	10a. State 10b. County	10c. City, T	own or Location						10d. Inside City Limits	
cto	Maryland Cecil	Pe	rryville	e					1X Yes 2 □ No	
Ē	10e. Street and Number		10	f. Zip Code			10g. C	itizen of What Co	untry?	
Funeral Directo	100 Greenway, Apartment 30)9	:	21903			United States			
ne In	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D	ecedent of H	spanic Origin? (Specify Yes or Norto Rican, etc.))-	14. Race - Ame Black, White		
	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 If Yes Give	No		es 21X No	Specify:	, ,		Specify: Whi	,	
g D	3 ☐ Widowed 4 ☐ Divorced Year or Dates:							Specify. ****		
ete	15. Decedent's Education (Specify only highest grade completed)	1	6a. Decedent's (Give kind o	of work done of	luring most of w	orking	16b.	Kind of Business/I	ndustry	
Be Completed by	Elementary/Secondary (0-12) College (1-4or 5	+)	life. DO No Fari	DT use retired)		Δ	gricu1tu	re	
္တ	17. Father's Name (First, Middle, Last)		Idli		18. Mother's Na	ame (First, Middle				
ğ O	Edgar Basham				Aldine	Starkey	7			
=	19a. Informant's Name/Relationship (Type. Print)	- 1	19b Mailing Add	ress (Street				or Town, State, 2	Zip Code) 21903	
	Evelyn E. Basham / Spouse 20a. Method of Disposition	20b. Plac	e of Disposition etery, crematory	(Name of	Apartme	il 17,	20c.	Location - City or	<u>Maryland</u> Town, State	
	Burial 2 Cremation 3 Removal from State		etery, crematory cipio Co			009	Dar	ruui 11a	Maryland	
d	4 □ Donation 5 □ Other (Specify) 21. Signature of Faperal S ce Licens	1 1 111	-			Crouch Fu			Halyland	
	21. Signature of Party and Control of Control							THE STATE OF THE S	ry1and21901	
	23a. Part 1. Enter the disease, or complications that caused	the death I						East, Ha	Approximate	
0	shock, or heart failure. List only one cause on each lir Immediate Cause (Final	ne.	JO HOT CITIES THE	Thous or dyin	y, suom as cara	ac of respiratory a	an ost,		Interval Between Onset and Death	
	disease or condition resulting in death)	ery	dre	12	an -				/ Weel	
	ane to (or as	a conse ir en	ce of):		2000	em &	P	turn	4 Vend	
<u>.</u>	Sequentially list conditions, b. Bue to (or as	(abmo								
Ē	cause. Enter Underlying Cause (Disease or injury	-		School						
Due to (or as a consequence of): any, leaduring in limiteclaic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
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ğ	u									
2	IF FEMALE: 23c. If yes, outcome							23d. Date of del	ivery	
sician/Medical	in the past 12 months? 1 □ Live birth			pic pregnanc er (s <i>p</i> ec <i>ify)</i> _	/			Month	Day Year	
S	9 Unknown									
<u>ک</u>	Part II. Other significant conditions contributing to death be	ut not resultir	g in the underly	ing cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
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plet	(138hogs 9 1-1	(el	W916	1 /48	cite	24a. Was		24b. Were au	itopsy findings available completion of cause of	
E						- auto perf 1 □ Yes	ormed?	death?	2 No	
e C	25. Was case referred to medical				26. Place of D	eath (Check only		10103	2 3 140	
0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ent 2 ∐ER	/Outpatient 3[DOA Oth	er: 4 Nursing	Home 5 ☐ Res	idence	6 ☐ Other (Spe	cify)	
Ë	27. Man of Death 28a. Date of Inju (Month, Date of	ry 28 v. Year)	b. Time of Injury	28c. Injur Work	y at	28d. Describe	how inj	ury occurred		
ا <u>ظ</u>	2 Accident investigation	,,,,,,,,,	M		Yes 2□No					
Certificatio	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	ury - At home c. (Specify)	, farm, street, fa	ctory, office		28f. Location City or To	Street a	and Number or Ruite)	ıral Route Number,	
ē										
edicai	29a. Certifier 1 ☐ Certifying Physician: To the best (Check only one) 2 ☐ Medical Examiner: On the basis on and manner sta	f examination	dge, death occu and/or investig	urred at the tir ation, in my o	ne, date and pla pinion, death oc	ice, and due to the curred at the time	e cause , date a	(s) and manner as nd place, and due	s stated. e to the cause(s)	
Med	one) and manner sta	ated.		29c. Licens	number		29d F	Date signed (Monti	h. Dav. Year)	
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	30. Name and address of person who completed cause of d	anth (line of	Pal Time Dulet	100				11/1	(
	SALANTI LA LA TETA	m() lo	R3 Some	zerl	7 Ave	, SIFT	m	MMD.	21921-	
	31. Date filed (Month, Day, Year) 32. Registro	ar's Signature		9	/				•	
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DHMH 17 Rev 1/200

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 20 2009 17:15 Andrew Allen Bishop, Sr. Apr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Union Hospital Elkton Ceci1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 XM 2 □ F June 2, 1925 West Virginia Director 171-20-9553 83 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Ceci1 Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2679 Jacob Tome Hwy. 21917 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ÄYes 2 □ No If Yes, Give Year or Dates: 1946-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White by 3 XWidowed 4 ☐ Divorced er than "natura the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Carl M. Bishop Lucy E. Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. Andrew A. Bishop, Jr./Son 2040 Colora Rd., Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04-25-2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. uchard soque 111 S. Queen St., Rising Sun, MD 23a. Part1. Enter the disease, or complications, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on/each line. Approximate Interval Between Onset and Death Immediate Cause (Final Premier **Physician** disease or conditio resulting in death) /Medical Due to (or as a consequence of): Examiner COPP Sequentially list conditions, if any, leading to immediate cause Enter to denying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed Exami arena physician and sthe burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Alzhen Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed? 1□ Yes 2☑ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1/Nnpatient 2 ER/Outpatient 3 DOA this 27. Manuer of eath 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending Physician: after death.

I Director: A id in by the fu within 24 hours aft

To the Funeral Di

completely filled in

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

In ceas No MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GILLA CHH H ,223 - Maly JU HD WOT 32, Registrar's Signature 31. Date filed (Month, Day, Year)

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Amended Item 20b per F.D. 04/20/2009 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, 2009 4c. County of Death April 10.10 A Orville Belcher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Virginia 1 M 2 □ F 236-07-5286 100 April 5, 1909 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, I'm Mcdical Examinating the nutities at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 □ No W Raleigh Beckley **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25801 U.S.A. 408 Timberidge Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3₺ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Methodist Church Reverend 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicey Mullins William Belcher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 Range Ford Dr., Owings Mills, MD 21117 Mary Cromey - Daughter 20c. Location - City or Town, State 20a. Method of Disposition Jarren Pistrain & The Cem. permit. Pages 1
Department of F
Important: If Ite
any injury or ot Burial 2 Cremation Removal from State Bald Knob, WV 4/19/2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Servic Jucensa 22. Name and Address of Facilit Pritts Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Securitally list norullions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last covertieily set coordinate Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burlal-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) signed by the s 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 KNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WIL 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 3337 Victory St., Manchester, MD 21102 John Middleton, MD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** ROSE MIGYON REDDICKS BOYD 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Plata edica Conter La If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 □ XF FFBRIARY 2. MARYLAND 216-24-8553 79 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f shov event, it a findion Exercises must be notified at 1 Yes 2 □ No Director WHITE PLAINS MARYI AND CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20695 UNITED STATES 4355 KATHY'S LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify ģ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene."
Important: If item 27 is marked other than "any injury or other traumatic event, If # 1/14 once." Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) PERSONNEL SPECIALIST FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH LOUISE COLES REDDICKS BRAXTON CHARLES HOBERT REDDICKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4355 KATHY'S LANE, WHITE PLAINS, MARYLAND 20695 CARLA V. BOYD / DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY APRIL 24, 2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Simure of Funeral Service Licens THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liny. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as 011 sician and burial-trans the death certificate be exect Due to (or as a consequence of): P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referr to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. May er of Death 1 V Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed, (Month, Day, Year) 29b. Signatur 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 17 Registrar

DHMH 17 Rev 1/2001

			Plea	se Type or					•		•	
		For State		State o	t Marylai		artment of F <i>rtificate of</i> .	lealth and N	Mental Hy		0000	11076
		Registrar 1. Decedent's Nam	ne (First, Middle	, Last)		Ce.	rincate or	Dealli	2. Date of D	Reg. No	2009	3. Time of Death
Physic /Med		Melvin	Leroy	Blizzard	, Sr.				Apri Apri	1 1	0 2009	9 8:40 p ^M
Exam				, give street and nu	mber)		4b. City, Town, o	r Location of Death		4c.	. County of Dea	th
		Golde 5. Social Security N		ng Center	7 Ane (In vrs	. last birthday)	Westing If Under 1 Year	inster If Under 24 Hrs.	8. Date of B	irth	Carro	thplace (State or Foreign
Funera Directo		215-26-8		15 M 2□ F		8 Yrs.	Months Days	Hours Min.	(Month, E	$\overset{\scriptscriptstyle(ay, \; Year)}{27}$	l Co	mplace (class of , oreign
pu »		Usual Residence o	Decedent 10b. County		100.0	ity, Town or Lo	noation					10d. Inside City Limits
Maryla f sho	ō	MD		roll	100.0							1 ☐ Yes 2 █No
n the l	Director	10e. Street and Nu	1	.1.011		Wesu	ninster 10f. Zip Code			10g. Cit	tizen of What Co	ountry?
illed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or Items 23a or 28a-f show ent, Ire Pericel Examination out to catilized and the contractions of the contractions		1246 De	er Park	Road			21	157			USA	
er dea items	Funeral	11. Marital Status		Armed Fo	edent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N Rican, etc.)	10-	14. Race - Ame Black, Whit	
urs aft	ğ	1 ☐ Never Marr 3 XWidowed		If Yes, Gi Year or D	ve		1 □Yes 2⊠No	Specify:			Specify:	White
72 hor	Completed	(Spe	15. Decedent	t's Education et grade completed)		(Give	dent's Usual Occup	during most of work	kina	16b. K	and of Business	/Industry
within sne.	I du	Elementary/Second		College (1-4or 5+)	`life.	Toolmake	d)		B1:	ack & De	acker
ial y allo 212 Should be filed withing and Mental Hygiene. Is marked other than aumatic event, the factors.	Be Co	17. Father's Name		Last)			1002.63	18. Mother's Nam	ne (First, Middl			
2 should be and Mental Is marked or raumatic ev	10 B	J. Vern	on Bliz	zard				Ethel	May Gl	over		
2 sho and land land land land land land land		19a. Informant's N					-	and Number or Ru				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Examinar must be notified and any injury or other traumatic event, in a Medical Examinar must be notified and any injury or other traumatic event, in a Medical Examinar must be notified as		20a. Method of Dis		ard, Jr/s				ark Road	Westm Date	,	ocation - City or	21157 Town, State
Pages nent of int: If it		1≹ Burial 2		3 Removal from	State		osition (Name of matory or other place of TIMC Com	etery 4/	/14/200		-	
permit. I Departm Importal any inju	ġ	21. Signature of F			100			reference				
0 88 E 8 8	3	Kar	053	Hono	V			ngton Roa			ster, M	
		shock, or hea	art failure. List	complications that only one cause on e	called the dea each line.	ith. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physiciar // Medica/		Immediate Cause disease or condition resulting in death)	on	a. Due to	www	psent	in the	edint				2 whe
Examine	r		111	l. ar	terra	ocless	the V	asento	e De	leas	~	26 lps
ed sit	iner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or	nmediate erlying	Due to	(or as a conse	quence of):	01.1					
e be executed sician and burial-transit	Examiner	that initiated event resulting in death)	IS	c. Due to	(dras a conse	quence of):	Xy was					ryp
eath certificate be exattending physician for use as the burian	_			L d								
ertifica ling ph	Physician/Medica	IF FEMALE:										
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w requires that the dispense signed by the should be detached	hysic	1 ☐ Yes 2 9 ☐ Unknowr		9 ☐ Unki		death 3						
S that	by P	Part II. Other signi	ificant condition	ons contributing to d	eath but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
requir	ted								1 [Yes 2	2. □ No 3 □ F	Probably 4 🗌 Unknown
ne law has t	Completed									is an opsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
an: Th tificate or, pag	(D)	25. Was case refe	erred to medical					26. Place of Dea	1 □ Yes	2 🗷		
nysich nis cer direct	To B	examiner? 1 ☐ Yes 2 2		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth				6 ☐ Other (Spe	ecify)
Attending Physician: The law ar death. rector: After this certificate has by the funeral director, page 2 s	on:	27. Manner of Dea 1 Natural	ath 5 🗌 Pendin	g 28a. Date (Mor	of Injury oth, Day, Year)	28b. Time of Injury	Wor	ry at rk?	28d. Describe			
ISIO Mittend death ctor: y	ficat	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could r	not be	e of Injury - At I	home, farm, st	M 1]Yes 2□No	28f. Location	(Street a	nd Number or F	Tural Route Number,
alor A	Certification:	4 Homicide	determ	build	ling, etc. (Spec	cify)			Cify or T	own, Stat	(e)	and rissis risings,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	edical (29a. Certifier (Check only one)	1 Certifyin 2 Medical	ng Physician: To the Examiner: On the l	e best of my kr basis of examination	nowledge, dea nation and/or i	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the	ne cause(e, date an	s) and manner and place, and du	as stated. e to the cause(s)
To the within To the Comple	Me	29b. Signature and	d title of certifier				29c. Licens	se number		29d. Da	ate signed (Mon	th, Day, Year)
WIL		1	Ann 4	1. ml	uth		DA	5443		41	13/2	009
10		-	iress of person	who completed cau	se of death (Ite	11		- + .			, A-3	21,02
S	tate	31. Date filed (Mor			Registrar's Sign		tory >t	reet, 1	land	- 10 1	a, m	D 21102
Regis			APR 1	4 2009	knews	B. 1	back					

09-03220 Tyrone M. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rone M. Brown	State of Maryland / Department 1- For State Certificate		giene Reg. No. 2009 1407
Physician/	Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 0755 hrs
edical Examine	Tyrone madrice brown Tyron maer	4b. City. Town, or Location of Death	April 22, 2009 U755 nrs
	Facility Name (If not institution, give street and number) Civista Medical Center	La Plata	Charles
E	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	218-83-0306 1X M 2 F	Yrs. Months Days Hours Min.	January 7,2009 CountMaryland
	Usual Residence of Decedent	TIS. 3 23	
any	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
thow ce.	MD Charles Waldorf		1 Yes 2 X No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
the Natified		20602	USA
r death with the Maryland or items 23a or 28a-f show any must be notified at once. Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. 1. X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- tican, etc.) 14. Race - American Indian, Black, White, etc.
r deatl	1 X Never Married 2 Married 1 Yes 2 X No		
s after ral", niner	3 Wildowed 4 Divorced in res, Give real or Dates:	Yes 2 X No specify: edent's Usual Occupation (Give kind of we	Specify: Black ork done 16b, Kind of Business/Industry
"natu Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DD NOT use retire	
36 hin 72 e. than edical	0	Infant	
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan	17. Father's Name (First, Middle, Last)	18.Mother's Name	First, Middle, Maiden Surname)
214 be fill mital F riked emt, t	Tyrone Maurice Nolan		arie Brown
D 21 thould mid Me is ma atticed			ural Route Number, City or Town, State, Zip Code) Apt. 16. Waldorf, MD 20602
MI 2 salth a calth a can 27		sposition (Name of cemetery,	Apt. 16, Waldorf, MD 20602 Date 20c. Location - City or Town, State
Ore ges 1 a of He If ite	1 Burial 2 X Cremation 3 Removal from State crematory of	or other place)	/00/00 01 - 11 - 11 - 11 - 11 - 11
timent transfer or o	4 Donation 3 Other Specify.	eld-Echols Crem. 4	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygerer in Department of Health and Mental Hygerer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Compilated by Filmeral Director		22. Name and Address of Facility AREHART-ECHOLS FUN	ERAL HOME, P.A. 20646
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not en	211 St. Mary's Ave ter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval Between Onset and
_/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexplained		Death
xaminer	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, b. If any, leading to immediate Due to (or as a consequence of):		
99	If any, leading to immediate Due to (or as a consequence of):		
led nisit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
be executed sician and urrial - transit	X UNPENDED XAMENDED 220 DIT 27	891 5/15/09 TT	
O, e be execut vsician and burial - tra	23a,PII,27,2	<u> 8a-f, perME, g893 7</u>	/6/09 TT
Box 6876(e death certificate the attending phytel for use as the box 6876(IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	
ox 6 th cer intendi	4 Pregnant at time of death 5	Other (Specify)	
by the green from the popular	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
i, P.O.	COncenital heart disease	the anastrying course given in the area.	1 Yes 2 No 3 Probably 4 Unknown
Records, The Jaw requires ficate has been signated by page 2 should be	Congenital heart disease		24a. Was an 24b. Were autopsy findings available
COT law ra has by			autopsy prior to completion of cause of death?
Division of Vital Records, tal or Attending Physician: The law require as a free death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a fiscential.	OS Wassess of south and south	26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
ital sician is cert irecto	Hospital:	1Other:	g Home 5 Residence 6 Other:
n of Vi	27 Manner of Death 28a Date of Injury 28b Tim	e of Injury 28c. Injury at Work?	28d. Describe how injury occurred
on on ending ath.	1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending Fd 4/22/09 Fd	5:10 am ¹ Yes 2 X No	unk
IVISION or Atteneather death Director: Lin by the	2 Accident Investigation 3 Suicide 6 X Could not be found at	street, factory, office building, etc.	28f. Location (Street and Number of Rural Route Number, City or Town, State) 2002 Amber Leaf P1.
Division of Vital Records, P.O. Box 68766 Ilospital or Attending Physician: The Jaw requires that the death certificate 4 hours after death. Funeral Director: After this certificate has been signed by the attending physely filled in by the funeral director, page 2 should be detached for use as the bear or attending physely filled in by the funeral director, page 2 should be detached for use as the bear or attending by the funeral director.	4 Homicide determined (Specify)		Apt 16, waldorf, Fid
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		occurred at the time, date and place, and	due to the cause(s) and manner as stated. If the time, date and place, and due to the cause(s)
To the He within 24 To the Fu	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		O.C.M.E.	April 23, 2009
	30. Name and address of person who completed cause of death (Item 23a)		
SB	Da and Manageri MD Assistant Medical Evaminer	111 Penn Street, Baltimore, M	D 21201
Stat	e 31. Date filed (Month. Day, Year) 2009 32. Registrar's Signature	parket	
Registra	APR 27 2009 Ceneva B.	LOV CILLEN	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2004 Lawrence C. Bivens, Sr. 2009 April 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 1509 Duke Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Hours 1 ★ M 2 □ F 217-30-9411 May 25, 1935 MD Director 73 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at ty∑Yes 2 No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21801 USA 1509 Duke Drive 23a Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠Yes 2 □ No Army
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ₫ 3 ☐ Widowed 4 ☑ Divorced 'natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, Its Manand Injury or other traumatic event, Its Manand Elementary/Secondary (0-12) 12 College (1-4or 5+) Driver/Salesman Beverage Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Milbourne George S. Bivens ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5909 Bost Lane, Clinton, MD 20735 Joy Richardson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/18/2009 Salisbury, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 21. Signature of Funeral Service Licensee Malson mark 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final **Physician** MUDCHAPIAC FEW MINNE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ MSU FFICIENCY 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

Jo the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only on-Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Nante and address of person who completed cause of death (Item 23a) (Type, Print)

B. TA LULAW — 850 CHUS KPETILL CUMBRIDGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 17 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené \(\bigcap \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy N. Christopher Brown 8:30 A M 21, 2009 Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stevensville Oueen Anne's 815 Dixon Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🕱 F 81 213-22-8092 Director 22,1927 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f shove event, the the deal Examined at 1 XYes 2 No Director MD Queen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Dixon Drive 21666 United States Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2x □xNo Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2XNo Specify: White Specify. 3 € Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) McCord Laundry Laundry/Dry Cleaners 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Floyd W. Coleman Emma May Fluharty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Dixon Drive, Stevensville, MD 21666 Dorsey Christopher/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Date permit. Pages Department of Important: If Its any injury or o 1 Burial 2 Cremation 3 Removal from State Junior Order Cemetery 04/24/09 | Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Mulare Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obtructive pulmonary disease **Physician** hronic Several years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): ng physician as the burial P.O. Box 68760, certificate be Physician/Medical IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P 1 Yes 2 No 3 Probably 4 Unknown Coronary anterv Completed Chronic congestive Lear 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform Angiodysplasia 1 ☐ Yes 2 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending I 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) April 22, 2009 29b. Signature and title of certifier 29c. License number

State Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paniel J. Konick, M.D. //5 Sallitt

31. Date filed (Month, Day, Year)

115 Sallitt Drive, Suite E Stevensville, MD 21666

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

		1 - State Registrar	ryland / Depa		leaith and Me Death	ental Hygie	•	14080
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Alfred Franklin Be 4a. Facility Name (If not institution, give street and number) 5074 Silver Hill Ct. Apt.	=11 T2	4b. City, Town, o	r Location of Death	Date of Death Month April 6,	2009 4c. County of Deat Prince G	
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, 18)		hplace (State or Foreign untry) rginia
the Maryland r 28a-f show	irector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges 10e. Street and Number	10c. City, Town or Lo			100	g. Citizen of What Co	10d. Inside City Limits Y☐ Yes 2☐ No untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Exprise must be notified at any Injury or other traumatic event, I'm Modical Exprise must be notified at any Dince.	by Funeral Director	5074 Silver Hill Ct. Apt. 7 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give	ver in U.S. 13.	2074 Was Decedent of H If Yes, specify Cub 1 □ Yes 2▼No	dispanic Origin? (Specian, Mexican, Puerto Ri	ify Yes or No- can, etc.)	United S 14. Race - Ame Black, White Specify: B	rican Indian,
l within 72 hours jiene. r than "naturai"	Completed b	3 ☐ Widowed ♣️ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+	(Give	DO NOT use retire	durina most of working		6b. Kind of Business/ Governmen	•
ould be filed I Mental Hyg Iarked other	To Be C	17. Father's Name (First, Middle, Last) Asaph Hall Bell			18. Mother's Name (First, Middle, Ma 3e11		
s 1 and 2 sh f Health and tem 27 is m other traum		19a. Informant's Name/Relationship (Type. Print) Linda B. Jackson / Daughter 20a. Method of Disposition		Elmaria		#228 W	,	,D.C. 20032
permit. Pages Department o Important: If i any Injury or once.		1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Lincoln	Memoria Name and Addre Alexande 5538 Mar	1 4/13,	/2009	Suitland,	
bhysician and physician and physician and the burial-transit	cal Examiner	Due to (or as a Congest Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to (or a	consequence of):	Arrest	ng, such as cardiac or —Chronic S			Approximate Interval Between Onset and Death
The law requires that the death certificate ate has been signed by the attending physoge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 □ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
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or Attending Physiter death. Director: After this in by the funeral di	Certification: To B	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Investigation Condition Cond	t 2 ER/Outpatier (Year) 28b. Time o Injury y - At home, farm, str (Specify)	f 28c. Inju Wor M 1 🗆	er: 4 Nursing Home ry at 28 k? Yes 2 No	e 5X Residen	nce 6 Other (Spe	
To the Hospital within 24 hours a To the Funeral I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the best of and manner state 29b. Signature and title of certifier	examination and/or in		opinion, death occurred	d at the time, da		e to the cause(s)
2		30. Name and address of person who completed cause of de	oth (Item 23a) (Type,	MD2	0414		4/9/2009	.,,
Bi		Georges C. Awah 106 Irving			OS Washing	ton. D.	C. 20010	

DHMH 17 Rev 1/2001

State Registrar Georges C. Awah 106 Irving Street NE suite 410S Washington, D.C.

Amend 19a, Joan, per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FD, CCHD, 4/21/09, drw State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16 2009 Physician Etta Jeanne Cross 4:55 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 10, 9. Birthplace (State or Foreign Country) Waryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours Min. 1□ M 2□ F 214-22-2427 86 192B Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f sho Maryland Calvert Prince Frederick 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 85 Hospital Road 20678 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

The strict flear 27 is marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or items 11 ury or other traumatic event, its "Medical Event manual ury or other traumatic event, its "Medical Event manual". 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lab technician health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin Barnes Bowen Etta Sheckells ည 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June C. Grover-daughter P.O. Box 435 St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery April 20, 2009 Barstow, Maryland 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20576 21. Signature of Euneral Service Licensee DIXau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of). P.O. Box 68760, physician Physician/Medical the ed by the attending prodetached for use as IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 I Unknown cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1 □Yes 2 📉 ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number April 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukesh Mathur M.D. 110 Hospital Rd. Prince Frederick, MD 20678 Denewa 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 17 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylar	•	artment of H			ental Hyg	iene	
			Registrar	() N		Cel	rtificate of l	Death		2. Date of Deatl	g. No. 200	9 1 1 0 8 2
	Physicia /Medic		1. Decedent's Name (First, Middle Altoria Coving							Month April 1	1, Day 2009 Year	22:00 M
	Examin		4a. Facility Name (If not institution	_			4b. City, Town, or		of Death		4c. County of Dea	
	Ö		Southern Maryl			t 4 t !- 4t - t \	Clintor If Under 1 Year		r 24 Hrs. 1	8. Date of Birth		Georges
	Funeral Director		5. Social Security Number 378–40–7374	6. Sex 1 □ M 2 1 F	7. Age (In yrs. 83	Yrs.	Months Days	Hours	Min.	Month, Day,	Year)	ountry) oerty, GA.
			Usual Residence of Decedent		0.5						,	
	rylanc	_	10a. State 10b. County			ty, Town or Lo	cation					10d. Inside City Limits
	8a-f s	cto		Georges	Sui	tland						1 🛣 Yes 2 🗆 No
	with th	Funeral Director	10e. Street and Number 3940 Bexley Pla	ce			10f. Zip Code 20746			11	og. Citizen of What C USA	ountry?
	ms 23	nera	11, Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Was Decedent of H	lispanic O	rigin? (Spec	cify Yes or No-	14. Race - Am	
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Maryland 2121	filed within 'Hygiene. Sther than "ent, I'm Wes	Completed	Elementary/Secondary (0-12)	College (DO NOT use retired th Care N				Private	
7	filed v Hygie ther t		12 LII • 17. Father's Name (First, Middle, 1	Last)			711 0010 11		ner's Name	(First, Middle, N	Maiden Surname)	
au	wuld be i Mental arked o atic eve	To Be	Ross B. Baker	,				Lel	lia Wi	lliams		
ary	sho sho	۲	19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (Street	and Numl	ber or Rural	Route Number	; City or Town, State,	Zip Code)
	1 and 2 Health a em 27 is other tra		Jimmy R. Adkins	/Son		4700	Brava Co	urt,	Fort	Washing	gton, MD.	20744-1107
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from			sition (Name of natory or other plac				20c. Location - City of	
Ē	. Pages tment of tant: If it		4 □ Donation 5 □ Other (S)	pecify)	Ple		Grove AME	_1			Hinesville	e, Georgia Avenue, N.W
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service		278		2. Name and Addre atney's F		,	* *		D. C. 20011
8760,	The law requires that the death certificate be executed x x hold be detached for use as the burial-transit at the detached for use as the detached for use at the de	dical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. C.	or as a consect	quence of):	Cillo	iov.	28Cul	Pay Di	Siase	Approximate Interval Between Onset and Death Company Con Know Co
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Division of	aior Attend sa erdeah Il Director	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be ined 28e. Place build	e of Injury - At h ling, etc. <i>(Sp</i> ec	nome, farm, str ify)	reet, factory, office		2	8f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
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	4		30. Name and address erson	who completed cau	ise of death (Ite	m 23a) (Type,	1/. 1	stoc	Yaz	dani,	M.D.	
		= 4	31. Date filed (Morlth, Day, Year)	Tany (Registrar's Sign	C 232	- CLIVI)	0~ /	رب.	20 15	7	
	Sta Registr			009 Jense	A.	free	6.8					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First. 8:20 PM 2009 13 APRIL RICHARD LEE VIRGIL COATES, JR. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day,) Sept. 3, 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 XM 2 ☐ F 79 1929 579-34-1191 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No St. Marys Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29449 Charlotte Hall Road U.S.A. 20622 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1951 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1953 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify. 3 XWidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Lee Virgil Coates Alice Elizabeth Lofty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L.V. Coates, III Son 115 Greenmont Circle, Alpharetta, GA 30009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2009 Suitland, MD Lincoln Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 8914 Quarry Road Bernard Ames Funeral Home, Manassas, VA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROYASCULAR disease or condition resulting in death) Due to (or as a consequence of): FIBRILLAS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): PAIEIJMONI A

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physician and cognitively filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical 2 Completed Be Certification: To

Physician

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination to rediffe 1 at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iter any Injury or other traumatic event, the Marical Examir

Physician

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Baltimore, Maryland 21215-0036

death with the Maryland

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that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal der 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic preg			23d. Date of delivery Month Day	Year
	ontributing to death but not resulting	g in the underlying caus	se given in Part I.		o use contribute to the caus	e of death? Unknown
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25. Was case referred to medical			26. Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 🌠 No	Hospital; 1 ☑ Inpatient 2 ☐ ER/	Outpatient 3 DOA	Other: 4 \(\tau \) Nursing H	ome 5 Residence	6 ☐ Other (Specify)	
	28a. Date of Injury (Month, Day, Year)		. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
27. Manner of Death 1 XNatural 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, o	ffice	28f. Location (Street City or Town, Sta	and Number or Rural Route ate)	Number,
📆 29a. Certifier 1 🔀 Certifying Ph	nysician: To the best of my knowled niner: On the basis of examination and manner stated.					use(s)
29h Signature and title of certifier		29c. L	icense number	29d. I	Date signed (Month, Day, Y	ear)

29c. License number *47655 29d. Date signed (Month, Day, Year) 14-16-2009

State Registrar

31. Date filed (Month, Day, Year) 7

2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I a mance Robelley, M.DAD, 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:45 A^M **Physician** 2009 11 **April** Ionia R. Clagett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 4065 Lomar Drive Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 22, If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🕱 F 1923 North Dakota 85 214-30-1379 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Martical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Frederick Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4065 Lomar Drive 21771 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Physician's Office Secretary is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vada Harry B. Row Aultman ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 4065 Lomar Drive Mt. Airy, Maryland 21771 George M. Clagett / Husband other t permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2009 Rockville, Maryland Parklawn Mem Park 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign vure Funeral Service Licer 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Colm Lances /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the death certificate as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year for 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has ormed? 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: Hospital or Attending (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 - Homicide filled 24 hours a Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39793 April 14, 2009 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1814 Pame Philip Dr. Olney, mis 20832

State Registrar

31. Date filed (Month, Day, Year) APR

Christopher J. Mays, mo 32/ Registrar's Signature

09-03166
Clara Carpenter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1. For State Certificate of Death Reg. No Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 20, 2009 1246 hrs Medical Examiner Clara Ardella Carpenter 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Civista Medical Center La Plata If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Min. Months Days Hours Director CountryMaryland 577-22-8496 2X F 88 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Maryland Charles Indian Head Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g, Citizen of What Country 10e. Street and Number 10f. Zip Code 67 Circle Ave. 20640 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 2 X No White f Yes, Give Year Specify Yes 2 No specify: Widowed 4 Divorced \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nt: If item 27 is marked other than "other traumatic event, the Medical Baltimore, MD 21215-0036 12 Clerk Insurance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Edwards Carpenter Ruth E. Cooksey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print.) Josephine Riley Sister 67 Circle Ave., Indian Head, Md. 20640 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) April 24, 1 X Burial 2 Cremation 3 Removal from State 2009 Indian Head, Maryland Charles Cemetery Donation 5 Other Specify MO3668

22. Name and Address of Facility
Williams Funeral Home, P.A.
4270 Hawthorne Road, Indian Head, Md.
ease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart nature of Fun fal Service Lic. Ma. Part I. Enter the Physician Between Onset and failure. Lig only ne cause on each line. /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease or condition resulting in death) kaminer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical 23a, PII, 27, 28a-f, perME, g891 5/18/09 TT X UNPENDED the attending physician led for use as the burial -AMENDED P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown 9 Unknown signed by 1 be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 V Unknown Hip Fracture Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 1 🗸 Yes certificate No he Hospital or Attending Physician: Th in 24 hours after death. he Funeral Director: After this certifica pletely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 Other: ER/Outpatient 3 ٩ 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Natural subject fell 1 Yes 2 X No Pending 4/20/2009 2 X Accident 12:15 pm Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 67 Circle Ave Indian Head, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide home determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 21, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year APR 2 Registrar's Signature State backs knews Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 4:15A. James V. Clark, Jr. 09, 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Charlotte Hall Charlotte Hall Veterans Home 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠ M 2□ F Director 03/08/1940 215-36-2838 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Upper Marlboro Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a USA Funeral 20772 5208 Charles Hill Blvd.Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 □Yes 2 No Specify: ģ Specify: Black 3 ☐ Widowed 4 ☑ Divorced "naturai" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Property management Maintenance engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F is marked of Gertrude Beander James Clark, Sr. ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. RaySean Clark/Daughter 5208 Charles Hill Blvd., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 04/17/2009 | Cheltenham, MD 21. Sign were of Funeral Service Ligense 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA HLZHEIMERS /Medical Due to (or as a consequence of): Examiner MELLITUS IABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Exam physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical CVA attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☑No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai Injury 5 Pending iours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 1 🗹 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

FRANCISCA BRUNEY, MD

29449 CHARIOTE HALL RD. CHARLOTTE HALL, MD 20622 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE SOUTHERN n MARYLAND HOSPITAL INTON 8. Date of Birth (Manth) Day (Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days South Carolina 1 ☐ M 2XXF 94 579-66-0473 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be nutilled at 1 ☐ Yes 2√ No Director Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or: USA 20748 2400 Afton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2XXNo Specify. **Black** þ 3√X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Stat Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F Elberta Cook Samuel Cook ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 161 Park Street Montclair, New Jersey Thames / Grandson Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 04/21/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee · Kels 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner INFECTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) RENAL burial-transit CHRONIC Due to (or as a consequence of) attending physician the use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A pletely filled in by the fu death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed o Division of Vital Records, Hospital or Attending Physician:

the Maryland

Maryland 21215-0036

Baltimore,

5 State Registrar

completely

within 2.

0

Name and address of person who completed

29a, Certifier

(Check only one)

29b. Signarage and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) APRIL 17TH 2009

of death (Item 23a) (Type, Print)

SURPATTS ROAD CLINTON MD 20735 1503

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** CARMEAN BURTON 7:50 AM 09 18 /Medical 4a. Facility Name (If not institution, give street and number); Charlotte Hall Veterans Fome 29449 Charlotte Hall Kd Charlotte Hall MD 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Marys charlott Hall MD Co. 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Hours Months Days 105-M 20 F 79 214-26-8718 onnecticu Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 Yes 2 □ No MD. Director St. Mary's Charlotte Hall · 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a 29449 Charlotte Hall Road 20622 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 0 1 ☐ Yes 2 🙀 No Specify: White þ 3 ☐ Widowed 4 🗓 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It e Man Elementary/Secondary (0-12) College (1-4or 5+) Upho1stery 8th Furniture Upholster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Edith Mary Jackson ပ Arthur Henry Carmean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 285 North Drive, Severna Park, MD 21146

Date 20c. Location - City or Town, State Mary A. Carmean/Sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐Other (Specify) MD Veterans Cemetery 4/22/2009 Hurlock, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 216 North Main Street Framptom Funeral Home, PA, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pich line. Approximate Interval Betwee Onset and D Immediate Cause (Final disease or condition resulting in death) 1000 Physician /Medical Due to (or as a con equi nce of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No ed by the detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 1 ☐ Yes 2 No 1 TYes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 NO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō 24 hours 29a, Certifier 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print) O Registrar's Signa 31. Date filed (M State Registrar

Registrar
7 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#23boerMD4-15-09, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alfonso Ignacio Alejandro del Valle 2009 **Physician** M q00:8 April 11, /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, November Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F 1955 53 Cuba 136-52-9357 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examinar must be notified at Takoma Park 1 ☐ Yes 2XXNo MD Montgomery Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA death with 20912 8301 Barron Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anet of Health and Mental Hygiene.
The filem 27 is marked other than "natural", or ite my or other traumalte event, I'm Modest Eventina. 1 ☐ Yes 2XX If Yes, Give Year or Dates: 2XXNo 1XXNever Married 2 ☐ Married White 1XXYes 2 □ No Cuban Specify. Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) None Elementary/Secondary (0-12) None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Gloria Portela Francisco Lorenzo del Valle ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 139 Woodgate Lane, Paoli, PA 19301 Sofie Minisi / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State April 13, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**XX**No 1 patient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide i 24 hours aft e Funeral Di letely filled in

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifie

Ava A. Kaufman

31. Date filed (Month, Day, Year)

15

DHMH 17 Rev 1/2001

ompletely

To the within 2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

8218 Wisconsin Avenue, Suite 103, Bethesda, MD 20814

and manner stated.

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 (1) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 12:30 pM 2009 12 Harriet Ostroff Dicker April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Rockville Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F New York Director January 14, 1930 133-22-4317 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show or 28a-f show notified at 1 X Yes 2 □ No Director Rockville Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 303 Adclare Road 20850 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify ò 3 X Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than ". Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress Librarian 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Hertz Libby Kurtzbard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 4100 Chippendale Court, Rockville, Maryland 20853 other t Vivian Sidner - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/14/2009 Mt. Lebanon Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Irigiry that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transi Due to (or as a consequence of): physician a Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 kg No 3 ☐ Probably 4 ☐ Unknown Osteoporosis page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2x No 2 ER/Outpatient 3 DOA 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide 24 hours 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 2 Seidmar

DHMH 17 Rev 1/2001

State

Registrar

Box 68760.

P.0.

Records,

Division or Vital

Aimee Jane Seidman, M.D., 15020 Shady Grove Road, Suite 300, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

15

D37801

April 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Shirley L. Di'l'ommaso April 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** Days Hours 1 □ M 2 □ xF 219-30-1625 1/9/1935 74 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 1 ☐Yes 2 TX No MD Carroll Westminster permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the "bedien Exercine coast but notified. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 300 St. Luke Circle Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) convenience store 12 store clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Pancoast Marcus Lanasa ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dina T. Foos, daughter 3714 Shiloh Road, Hampstead, Md. 21074 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 4/15/2009 Hampstead, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Eline Funeral Home M00741 land 934 S. Main Street, Hampstead, Md. 21074 Denumer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 Heart and Calon be executed Exami and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the Physician: The law requires that the death certificate as attending IF FEMALE nse s 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year ρ in the past 12 months 5 ☐ Other (specify) ☐Yes 2 NA ed by the a P.0. 9 D Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 100 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 11 Other (Specify) 1∐ Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE After 1 Hospital or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only one and manner stated. To the }

NEL

Registrar

State

29b. Signature and title

SR

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

32. Re

Year)

APR 16

Kaneua

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

14092

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at aprice. Baltimore, Maryland 21215-0036

> Physician /Medica Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Cei	rtificate of L	Death	Re	g. No. 2 UUS	14092
	Decedent's Name (First, Middle, Last)			-	2. Date of Death		3. Time of Death
ian	John Russell Dove				Month April 1	Day Year 5, 2009	8:55 A M
ical ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1101	4c. County of Dea	
ilei	5909 Harrison Avenue		Riv	erdale		Prince	George's
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
1	217-42-2723 ^{1⊠M 2□ F} 6	6 Yrs.	Months Days	Hours Min.	July 29,	1942 Fal	ou <i>ntry)</i> L1 River, MA
	Usual Residence of Decedent						
١,	, ,	0c. City, Town or Lo	cation				10d. Inside City Limits
cto	Maryland Prince George's	Riverdal	e				1 X Yes 2 □ No
Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	country?
	5909 Harrison Avenue		207	37		USA	
Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Wh	
五	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		1 □Yes 2 🕱 No	Specify:	,		Vhite
Be Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:						
ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup- kind of work done of	turing most of work		6b. Kind of Business	
ם	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired er HVAC-R	•		Heating A	And Itioning
ပိ	2	OWII	er nvac-k	18. Mother's Name	- (First Middle N		CIONING
	17. Father's Name (First, Middle, Last)						
၉	Walter Joseph Desales Dove				Marie Bo	1	
	19a. Informant's Name/Relationship (Type. Print)		•			City or Town, State,	, Zip Code)
	Dawn Pefley / Daughter		Ridge Roa			Oc. Location - City of	r Town State
	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei					
	4 □ Donation 5 □ Other (Specify)	-	an Cremato	-			a Virginia
	21. Signature of Furieral Service Licensee)	2. Name and Addres				imore Avenue
	Jews IT Celman						le, MD 20781
	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition Atherosc.	Lerotic D:	isease				Onset and Death
	resulting in death) Due to (or as a continuous)	consequence of):					
۱.	Sequentially list conditions b.						
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):					
(am	Cause (Disease or injury that initiated events c						
Ē	resulting in death) Last Due to (or as a c	consequence or):					
Medical	d						
Me	IF FEMALE:	1.6					
ian	23b. Was decedent pregnant in the past 12 months?	□ Fetal death 3 L	Ectopic pregnanc	у		23d. Date of d Month	lelivery Day Year
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	me of death 5 L	Other (specify)				
by Physician	Part II. Other significant conditions contributing to death but it	not resulting in the u	nderlying cause give	en in Part I	23e. Did tob	acco use contribute	to the cause of death?
þ	Takin Silisi Sigimisan Sanahasi Sanahas	tot rooming in the d	noonying cause give				Probably 4 ☐ Unknown
sted							
du					24a. Was ar autops	24b. Were	autopsy findings available completion of cause of
Completed					perform	ned? death′ ☑No 1 ☐ Ye	s 2 🗆 No
Be	25. Was case referred to medical examiner?		T out	26. Place of Deat	th (Check only one	9)	
ျ		2 ER/Outpatie		4 LI Nursing H		nce 6 Other (S	pecify)
Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, \)	/ear) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
cat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury			Yes 2□No			
E	4 Homicide determined 28e. Place of injury building, etc.	- At home, farm, sti (Specify)	reet, factory, office		City or Town	eet and Number or , State)	Rural Route Number,
	29a. Certifier 1 🖾 Certifying Physician: To the best of					(a) and manage	an atatad
Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of (Check only one) 2 ☐ Medical Examiner: On the basis of e and manner state	xamination and/or in					
Mec	29b. Signature and title of certifier	<u>. </u>	29c. Licens	e number	2:	od. Date signed (Mo	nth, Day, Year)
	Man A DX		560	-		14/17/	09
	20 None and address of	th /Itam 20a\ /T				3.111	
	30. Name and address of person who completed cause of dea Daniel Jerome Fernicola, Jr			vo Road	#306 Pa	okwilla	MD 20850
ote				ve Road,	17300, KC	CKATTIE	ED 20000
tate trar	APR 2 0 2009 Comme	S Signature	west				
	Men a contract						

Regis DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:30 P M 4/14/2009 WALTER L. EDWARDS, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HEARTLAND NURSING HOME HYATTSVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. 1 3KM 2 □ F 10/30/1925 Baltimore, MD Director 219-10-7872 83 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show 1 Tx Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2239 Mount View Place SE 20020 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Services Cook 12 should be filed w h and Mental Hygie 7 **is marked other t**l 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter L. Edwards Sr. Elsie Fallon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important; If Item 27 is any injury or other traus 2239 Mount View Place SE Washington, D.C. 20020 Betty Edwards / Wife Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/16/2009 Alexandria, VA Metropolitan 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy requires that the death in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No. the detached 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has page 2 s autopsy performe this certificate 1 ∐Yes 2 MNo Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? After Certification: Division To the Hospital or Attending 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

To the Funeral Director; After th completely filled in by the funeral after within 24 hours a

6 3 State

Medical

Registrar

filed (Month, Day,

29a, Certifier

29b. Signature

32. Registrar's Signature 1. face

and manner stated

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) APRIL 15 2009

who completed cause of death (Item 23a) (Type, Print) PARKNAY GREGEBELT MARTLAND 20770 7325A HAMOVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:16 FLETCH EVR **Physician** RARBARA 10 2009 JO /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** 1 M 2 X F 6/1/1950 58 Maryland Director 218-56-8807 Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City. Town or Location 10a State 10b. County 1X Yes 2 □ No Director Anne Arundel Laurel 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number 20724 USA items 23a 442 Old Line Ave. Funeral must 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status ed other than "natural", or iter event, the Medical Examiner 1 ☐ Yes 2X If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3altimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ₹ Divorced 16b, Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Food Warehouse 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ruby Smith Oscar Childers မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 it 1309 Holly St., Shadyside, MD 20764 James Fletcher/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/09 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service Licenses PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYDGARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MONARY Seque dally list on this if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine SCIEROBERME Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) physician ants the burial-t by Physician/Medical Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 1 Yes 2 No 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed: 2 No 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28 No 2 ER/Outpatient 3 DOA 1 🗌 Yes မ this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral Certification: Injury After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. **Director:** 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) completely and manner stated.

ren

within 2 To the I

30. Name and address of person who completed cause of death (hem 23a) (Type, Print) YN 133 NILKY

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

MS

State Registrar 29c. License number

RSS-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar/MFND#24aperMD4-17-09, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 14 2009 7:35 рм April Leonard Fishbein /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) 01/25/1929 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min 1 🖳 M 2 🗆 F Months Davs Hours 80 Yrs Wash. D.C. Director 579-34-2194 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ire Medical Examiner must be notified at 1 √Yes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 13809 Arctic Avenue 20853 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?

1 ★Yes 2 NoAirforce
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 9 3 Widowed 4 Divorced Year or Dates: 48-50 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hair Hair Styling Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yetta Ehrlich Harry Fishbein ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health al
Important: If item 27 is i 13809 Arctic Avenue Rockville, MD 20853 Adele S. Fishbein - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/09 Olney, MD Judean Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityDanzansky-Goldberg Memorial Chapel 21. Signature of Funeral Service License Gonald 1170 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstructive Pulmonary Sequentially list conditions Examine n any, leading to infinediate cause. Enter Underlying Cause (Disease or injury certificate be executed attending physician and for use as the burial-transit 5 years Due to (or as a consequence of): CAWCEV that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 No 3 Probably 4 Unknown ed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Complet 24a. Was an certificate has page 2 autopsy 1 □ Yes 2 No Division of Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu death. investigation 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4-14-2009 and 10 039190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar rett

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Day Year)

31. Date filed

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Registrar's Signature

18101 Prince Phillip Dr Olney, MD 20832

		I- For State Registrar		Cert	ificate of L			l J ien	Reg.	No. 2	009	
Physici	an/	Decedent's Name (First, Middle,L						Mont	of Death h D	ay Year	3. Time of 1839	
cal Exami		PHILLIP 4a. Facility Name (if not institution,	CAL		FORD	City, Town, or	l ocation of [5, 2009	4c. County o		
		S/B Harry S. Truman Dr		er)		_argo	LOCUMON OF L	70411		Prince G		
Funeral				Age (In yrs. las	t birthday)	If Under 1 Year			te of Birth (MM/DD/YYYY)	9. Birthplace (Sta	ate or I
Director		220-70-4080	Хм 2 г	50	Yrs.	Months Days	Hours	Min. SE	PT 14	4 1958	Country) MARYLAN	D
		Usual Residence of Decedent									10d. Insid	e City
w any		10a. State 10b. County	GEODGE ! G		own or Location						1 X Ye	
yland r-f she	흕	MD PRINCE 10e. Street and Number	GEORGE'S		LANDOVE	10f. Zip Code			10g	. Citizen of Wh		
Baltimore, MID 21215-UU36 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		T DOAD # 2			2078	5			USA		
vith the s 23a e noti	la [2304 BRIGHTSEAT	12. Was Decede	ent Ever in U.S	. 13. Was	Decedent of His	panic Origin	? (Specify Ye	es or No-	14. Race	- American Indian,	, Black
Jeath v r item	nue	1 X Never Married 2 Marr	ried Armed Force	es? 2 X No	If Yes	, specify Cuban	, Mexican, P	uerto Rican,	etc.)	White		
after (by F		ced If Yes, Give Year or Dates:			es 2 X No			- 12		BLACK	
hours natur Exam	pa	15. Decedent's Education (Specif	y only highest grade of College (1-4	,	16a. Decedent's during mos	Usual Occupat t of working life			ne 1	66. King of Bu	siness/Industry	
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ygiene ygiene other	Completed	12TH 17. Father's Name (First, Middle, L.	ast)		LADORE		18.Mother's	Name (First,	Middle, Ma	iden Surname		
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Baltimore , permit. Pages 1 ar Department of Her Important: If ite injury or other tringury or other tr		4 Donation 5 Other Spe 21. Signature of Fereral Service I		RI	VERDALE	CREMAT		4/15/2			DALE, MARY FUNERAL H	
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/Medical		failure. List only one cause of Immediate Cause (Final disease	a. Multiple Blun	t Force Inju	ries							Death
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	•	For State Registrar	2	, ,	•	rtificat		ealth and N Death		g. No. 2	109	14097	
		Decedent's Name (First, Middle, Last	st)						2. Date of Death Month	Day	Year	3. Time of Death	
Physicia /Medic		Vernon Theo	dore 0	Gott,	Sr.				April 1	3 200)9	7:00 A M	
Examin		4a. Facility Name (If not institution, give	e street and numb	per)		, ,		Location of Death		4c. County			
		Atria Manresa 5. Social Security Number 6. S	ex 7	. Age (In yrs. i	last birthdav)		nnapo	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
Funeral Director			M 2□ F	82	Yrs.	Months	Days	Hours Min.	(Month, Day, 06-28-1	926	Mar	yland	
pu 🖈		Usual Residence of Decedent		100 Cit	y, Town or Lo	cation						10d. Inside City Limits	
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or ite	by Fu	1 ☐ Never Married 2 📉 Married	1 ∐Yes 2 If Yes, Give	™ No		1 ∐Yes		Specify:	, ,	Specify	/: •		
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2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Ever ther rough be notified at	Completed	12	- College (1 4		autor	mobi1		chanic				repair	
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d 2 st Ith and 17 is r traur		19a. Informant's Name/Relationship (Type. Print) Jessie Woodfield Gott, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4722 Woodfield Road, Galesville, MD 20765											
f Heal		20a. Method of Disposition	00LL, W.		Place of Dispo					20c. Location -			
Page:		1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ate	odfiel			1	17-2009	Galesv:	ille	, MD	
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		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that car one cause on eac	used the deat ch line.	h. Do not en				c or respiratory arre	est,		Approximate Interval Between Onset and Death	
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To th Within To th COMP	Me	29b. Signature and title of certifier				29c. License number 29d. Date signed				ed (Mont	th, Day, Year)		
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ORW IA State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year April 12 2009 11:15 P M **Physician** Laverne Grover /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 4750 St. Leonard Road St. Leonard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Oct 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Maryland 1921 220-34-4957 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or Items 23a or 28a-1 sho any injury or other traumatic event, it elsested. 1 □Yes 2 □ No Director Maryland Calvert St. Leonard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4750 St. Leonard Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 🖺 No Specify If Yes, Give Year or Dates: ģ 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Postmaster US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilmer Guy Elliott Helen Eileen Sewell 19a. Informant's Name/Relationship *(Type. Print)* Wayne W. Grover— son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 435 St. Leonard MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul Cemetery April 15 2009 Lusby Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20576 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final menth **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🔊 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 14 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the I within 2. dRW lo State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar Munshi, MD 31. Date filed (Month, Day, Year)

3 🗌 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

Hospital Road Prince Frederick MD 20678

and manner stated

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registraris Signature 2009 Barks

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 14 2009 2:05 Α Goodman April Audrey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick
Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🖾 F 1922 12, North Carolina 86 Dec. Director 229-18-8941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Words I Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21703 <u>United States</u> 5 Linden Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nanny Blanche Matthews James Melvin Ellis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Lee Goodman/ Daughter Linden Avenue, Frederick, Maryland 21703 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sxauffer Crematory Inc. 4/19/09 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licen 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 gm veres rencesch a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner temm haras Sequentially list souditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transi homeic Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ No 1 ☐ Yes 2 ☐ No ospital or Attending Physician; hours after death. uneral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manger of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signal re and title of certifier 29c. License number

State

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Registrar APR 17

Date filed (Month, Day, Year)

400 West 7th Street, Frederick, Maryland 21701
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHIRAMS

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 April 11 10:20 pM **Physician** Austin Jerome Grav /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Days Hours Min 1 ☑ M 2 □ F Yrs Nov 4 1945 Maryland 63 Director 213-44-5809 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedical Examiner must be notified at 10a. State 1X Yes 2 □ No Director Lanham Prince George's death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20706 8912 Fairview Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify by 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private s 1 and 2 should be filed of Health and Mental Hyginitem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Thomas John A. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5105 Britten Lane, Ellicott City, MD 21043 Paul-Sean Gray/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1 Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Port Tobacco, MD 4/18/09 St Catherines Catholic 4 ☐ Donation 5 ☐ Other (S 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Eureral Service icensee a Solo 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine burial-trar and Due to (or as a consequence of): Box 68760, attending physician the death certificate be Physician/Medical the as esn yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Dav Po 5 Other (specify) signed by the a P.0. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2 ☑No certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🖾 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred Phospital or Attending P 24 hours after death.
Funeral Director; After t letely filled in by the funera After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

23044

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

DR. 309 CTIZ.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03332 State of Maryland / Department of Health and Mental Hygiene Stephen Grozdanich 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 25, 2009 1940 hrs Medical Examiner Stephen Owen Grozdanich c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days Country)Florida Director 1 XM 2 F 90-50-1716 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location iny. 1 Yes 2 X No 28a-f show notified at once. Maryland Montgomery Germantown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19238 Warrior Brook Drive 23a 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married Never Married 1 X Yes Yes 2 X No specify: If Yes, Give Year 1991-95 3 Widowed 4 Divorced White ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene. Aerospace Engineering Company 12 ogistics Engineer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Theresa Stephens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be Peter James Grozdanich 19a, Informant's Name/Relationship (Type, Print) Germantown, MD. 20 20c. Location - City or Town, State Brandy E. Grozdanich, wife 9238 Warrior Brook Drive. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State ment c 4/28/2009 Alexandria, Virginia Metropolitan Crematory Other Specify: Donation 5 22. Name and Address of Facility Molesworth-Williams Funeral Home Signal re of Funeral Service Dicensee 26401 Ridge Road, Damascus, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure List only one cause on each line /Medical Death Acute coronary artery thrombosis complicating diat Cause (Final disease xaminer Due to (or as a consequence of): atherosclerotic cardiovascular disease or con it is n resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last put AMENDED 23a,27, perME, g891 5/20/09 TT Physician/Medical physician a XUNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Fetal death 3 Ectopic pregnancy Month Dav Live birth cate has been signed by the attending page 2 should be detached for use as t past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of certificate has death? performed' Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical director. Be examiner? Hospital: Other₄ Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 After this ۵ 1 Yes funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending

the Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number OCME

address of person who completed duse of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

O.C.M.E.

April 26, 2009

31. Date filed (Month, Day, Year) State Registra

Theodore M. King, Jr., MD.

32. Registrar's S

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State	of Marylai		artment of F rtificate of				giene Reg. No. 2	119	11.102
	Dharist		1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath	Year	3. Time of Death
	Physicia /Medic	al	Robert Ernest				41. 63. T		of Dooth	April	13,200	9 y of Death	5:10pm M
	Examin	er	4a. Facility Name (If not institution, the Hebrew Home of			zton	4b. City, Town, o		or Death			gomer	
	Funeral Director			. Sex 14 M 2 □ F	7. Age (In yrs		If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da Sept 1	th av. Year)	9. Birth	place (State or Foreign ntry) York
	D		Usual Residence of Decedent										· · · · · · · · · · · · · · · · · · ·
	arylan show		10a. State 10b. County			ity, Town or Lo							10d. Inside City Limits 1 ☐Yes 2 ☐ No
	the M	Director	MD Montgo	mery		Silver	Spring 10f. Zip Code				10g. Citizen of	What Cou	Λ
	3a or		504 Waterford R	d			20901				United	Stat	es
	ems 2	Funeral	11. Marital Status	Armed F	edent Ever in U	J.S. 13.	Was Decedent of I	lispanic C an, Mexic	origin? (Sp an, Puerto	ecify Yes or No Rican, etc.))- 14. Ra	ace - Ameri ack, White,	can Indian, etc.
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	d 1X∏Yes lfYes, G Yearor[2 □ No 19:	38	1 □Yes 2 X No	Specif			Spec	ify: Whi	.te
5-0	72 hou	Completed	15. Decedent's (Specify only highest	Education grade completed,		16a. Dece	edent's Usual Occu kind of work done	during mo	ost of work	ing	16b. Kind of I	Business/In	dustry
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Mary	nd 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationship Karen L. Clark/		.	1	ng Address <i>(Street</i> Waterfor						
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examination institution once.		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		i State		osition (Name of matory or other pla			Date 5-2009	20c. Location	•	own, State
Balti	permit. I Departm Importa any Inju		21. Signature of Funeral Service Li		,	2	2. Name and Address 130 Wisc	ess of Fac		-			
			23a. Part 1. Enter the disease for conshock, or heart failure. List of	omplication at	caused the dea	ath. Do not en	iter the mode of dy	ing, such a	as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	P	NEU	MONIA						Onset and Death
	/Medical Examiner		resuming in deam)	Due to	(or as a conse	quence of): $\angle NOU$) 51 (3 A	CT	ERI	4		
		ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a conse		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0 1-17			
7	xecutec and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
∑ A 8760,	cate be executed ohysician and the burial-transit	dical E		d									
H C C	eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of preg birth 2 Fe gnant at time of nown	tal death 3	□ Ectopic pregnan	су				ate of deliving	very Day Year
rds, P.	w requires that the d s been signed by the should be detached	þ	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	underlying cause gi	ven in Par	t I.		tobacco use co		the cause of death?
C BER	Physician: The law red this certificate has bee ral director, page 2 shou	Completed								24a. Was auto perf	opsy ormed?	prior to c death?	opsy findings available ompletion of cause of 2 □No
Vital	clan: sertifica sctor, p	Be C	25. Was case referred to medical examiner?				100		ace of Deal	th (Check only			# x* 4 m r
of \	Physl this cral dire	<u>۲.</u>	1 Yes 2 No		Inpatient 2	ER/Outpatie	ent 3 LI DOA		Nursing H		how injury occ		ify)
	n ding Ph th. : After thi e funeral	tion	1 Latural 5 ☐ Pending 2 ☐ Accident investiga		e of Injury onth, Day, Year)	Injury	Wo	rk? ∐Yes 2∣	□No	200. 2000.120			
Division	or Attend after death Director: / d in by the f	Certification: To	3 Suicide 6 Could no determin	t be ed 28e. Plac buil	e of Injury - At ding, etc. (Spec	home, farm, st	treet, factory, office			28f. Location City or To	(Street and Nur wn, State)	nber or Ru	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the	ne best of my k basis of exami nner stated.	nowledge, dea nation and/or i	ath occurred at the investigation, in my	time, date opinion, d	and place death occu	e, and due to th	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
_	To the To the comple	M	29b. Signature and title of certifier	P		244 0	29c. Licer	ise numbe	08	ı/	29d. Date sign	ned (Month	, Day, Year)
	4		30. Name and address of person w	1		em 23a) (Type	1/	0	0 4	POT 11	VIII 1	14 un 2	ef0-
	Sta	ite	31. Date filed (Month, Day, Year)	32	Registrar's Sig		1/2 (1/20-3	= /-	1	wa.	ving !	11) 2	0002
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar		artment o			ntal Hy	giene Reg. No.		14103
	* * *		1. Decedent's Name (First, Middle	, Last)					2	2. Date of De	aath Day	Year	3. Time of Death
h	Physici /Medic		Emily May Holst	ein						April			4:30 A. M
	Examin		4a. Facility Name (If not institution	, give street and numb	cer) Ce	nter	4b. City, Tow	n, or Location	of Death		4c.	County of Deat	h
1.4			Potomac Valley				Rockvi		0411-			ntgomer	·
- (5) ABI	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	B. Date of Bir (Month, Da	ay, Year)	9. Bin	hplace (State or Foreign buntry)
	Director		578-56-1832 Usual Residence of Decedent		07					NOV. 1	.3, I	941 Was	hington, DC
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mar	ţċ	Maryland Monte	gomery	S	ilver S	Spring						1 ☐ Yes 2 No
	th the	irec	10e. Street and Number				10f. Zip Coo	de			10g. Citi	zen of What Co	ountry?
	23a	ai	10314 Naglee Ro	ad			20	0903				ed Stat	
	er de	Funeral Directo	11. Marital Status	12. Was Deced Armed Forc	es?	.S. 13.	Was Decedent If Yes, specify (ol Hispanic Ori Cuban, Mexicar	igin? (Speci n, Puerto Ri	ify Yes or No ican, etc.)	0-	 Race - Ame Black, Whit 	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ XDivorced	ied 1 ☐ Yes 2 If Yes, Give Year or Date			1□Yes 2≹	No Specify:	:			Specify: Wh	ite
9500-91212	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-f ehow ent, Ira Madical Exam ner mun be motified at	ed	15. Decedent			16a. Dece	dent's Usual Oc	cupation			16b. Ki	nd of Business	
ر دار	hin 73	Completed	(Specify only highes Elementary/Secondary (0-12)	college (1-4	for 5+)	(Give	kind of work do DO NOT use re	one during mos itired)	st of working	7			
7	giene giene er the	N N	12	J Comogo (Admin	istrati	ve Ass	istanı	t	US	Governm	ent
2	9 7 5	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Middle	, Maiden	Sumame)	
Хa	should be ind Mental marked o umatic eve	2	Ken	Harris				Loui				AILABLI	
Maryland	2 2 2		19a. Informant's Name/Relations									r Town, State,	
	1 and Health em 27 ther tr		Daniel Green, S 20a. Method of Disposition	on	20h F	_	Naglee		SILVe			MD 209 ecation - City or	
Ď	Pages nent of h int: if its ury or of		1 🗆 Burial 2 🛣 Cremation		ate	cemetery, crei	matory or other	place)	April	14,			
Baltimore,	artme artme ortani injury		4 □ Donation 5 □ Other (Single 21. Signature of Funeral Service		AL		Cremat Name and Ad		2009		Glen	Burnle	, Maryland
n	permit. Pages Department of I Important: if it ony injury or o			1 00 m	M01508	Ī	hibadea	u Morti	uary (Servic	e. P	A. ing, MD	20910
	1.0		23a. Part1. Enter the disease, or	complications that cau	used the deat				•			1116, 111	Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final			ZTITAT A							Onset and Death
	/Medical		disease or condition resulting in death)	a. CARDIA Due to (or	r as a consec								
	Examiner		Sequentially list conditions	b									
	ש א	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying		r as a conse	uence of						_	
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (e									
/60,	ate be executed hysicien and he burial-transit		rooding in doubly 2000	Due to (or	r as a consec	luence or):							
789	death certificate be executed e attending physicien and id for use as the burial-transit	dicai		d.									
ROX	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Date of de	livery
ň	death e atte d for	icia	in the past 12 months?	4☐ Pregnar	th 2 ☐ Feta nt at time of c		⊒Ectopic pregna ⊒ Other (specify					Month	Day Year
J.		hys	9 Unknown	9□ Unknow	vn								
	d de	ру Р	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part I	1.				the cause of death?
g	w requires t been signe should be		DEMENTIA							1 🗆	Yes 2	XINo 3∏P	robably 4 Unknown
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Vital	Phyeicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:					e of Death	Check only	one)		
6	this ald	2	1 Yes 2 No 27. Manner of Death]		ER/Outpatier	nt 3LL DOA			e 5 🗌 Res		6 Other (Spe	ocify)
	ling After fune	tion	1 XNatural 5 ☐ Pendin		Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 ☐		od. Describe	TIOW TIPUI	y occurred	
DIVISION	al or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could i	not be 290 Blace o	f Injury - At h	ome, larm, st	reet, factory, off			31. Location	(Street an	d Number or R	ural Route Number,
2	al or / s after i Dire d in b	Certification:	4 Homicide	building	g, etc. <i>(Speci</i>	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State))	
	ne Hoepital or a 24 hours afte ne Eunerel Dire			g Physician: To the b									
	To the H within 24 To the F complete	Medical	one)	Examiner: On the bas and manne	or stated.	ation and/or in			atir occurre	at the time.			
	To the within 2 To the complet	2	29b. Signature and title of certified	5~	~		29c. Lic	cense number			29d. Da	te signed (Mon	in, Day, Year)
•	ν		23	4				2435			Apri	1 13, 2	009
			30. Name and address of person					TO DO	ck===11	la Min	200	50	
10	Sta	to	Sayed M. Elsayy 31. Date liled (Month, 'Day, Year)					ve, KO	CKVII.	re, rm	200	JU	
100	Registr			2009 Sent	un p	. pa	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:45 A Gisele Hill April 2009 15. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Montgomery Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗑 F 11/24/1917 577-40-9874 91 Director France Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examiner must be confined once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director Maryland Prince George's Forest Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5505 Sachem Drive 20745 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: þ White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) French Embassy Administrative Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladieux Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6200 Mass. Ave. Bethesda, MD. 20816 Marc-Henri Vidal/Pastor 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition txxBurial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2009 Clinton, Maryland 4 □ Donatio 5 ☐ Other (Specify) Resurrection Cemetery Funeral Service Licer 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events satisfied doubt). Due to (or as a consequence or) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached f 1 ☐ Yes 2 🛛 No o 9 Unknown o. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives in Part I. Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2 K No 1 ☐ Yes Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ot 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Division 1 🗶 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. was 29b. Signature and title of certified

Registrar

DHMH 17 Rev 1/2001

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State

GISELE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bullar Dr. Rockville, MD 20850

9-02698		Please Type or Print in Black in			ie.
ernon A Holm			rtment of Health and Mental Hy	ygiene	2000 11105
		Registrar	tificate of Death	Reg. No	
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death
Madical Exam	iner	VERNON A. HOLMES- BEY SR.		April 5, 2009	1252 hrs
)		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		3903 73rd Avenue	Hyattsville		Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la			M/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director		579-66-6099 1 x M 2 F 58	Yrs. Months Days Hours Min.	8/20/195	
		Usual Residence of Decedent		10/20/193	0 Washington, DC
any			Town or Location		10d. Inside City Limits
A		Manual and Durings Commodes I or	ndover		1 X Yes 2 No
Maryland 28a-f show d at once.	cto	Maryland Prince George's Lar 10e. Street and Number	10f. Zip Code	10a. C	itizen of What Country?
e Ma or 28	Director			4	
5-0036 led within 72 hours after death with the Maryland bygiene, other than "natural", or items 33a or 28a-f sho ther than "natural", or items 33a or 28a-f sho the Medical Examiner must be notified at once.		3903 73rd Ave.	20784		ted States
th wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 		14. Race - American Indian, Black, White, etc.
r dea	Ē	1 Yes 2 X No			
afte ral",	þ	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Black
hours natu		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired.)		. Kind of Business/Industry
6	let	Elementary/Secondary (0-12) College (1-4 or 5+)	-	•	
5-0036 led within 72 hours afte Tygiene. other than "natural?" the Medical Examines	Completed	12	Electrician		Private
15-0 filed w J Hygie ed othe		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maide	n Surname)
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be	Vernon Allen- Holmes-Bey	Juanita		
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F	·	· ·
imore, MD 2 Pages 1 and 2 shou nent of Health and N sant: If item 27 is n or other traumatic		Vernon Allen Holmes Jr. / Son	6415 Elmhurst St. Dis		
Heal Heal			Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or Town, State
nother		Bullar 2 21 Clemation 3 Removalition state		1/2000 11	Lexandria, VA
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is m injury or other traumatic.	- 5	4 Donation 5 Other Specify: Met 21. Signat on Funeral Service e	22. Name and Address of FacilityPope	Funeral	Homes. P.A.
Balt permit. Departs Import	l d	MATOUR	5538 Marlboro Pike		
Physician		23a. Part I. Enter the disease, all complications that caused the death.			
/Medical		failure. List only one cause on each line.	., .,		Between Onset and Death
Examiner		Immediate Cause (Final di lease or condition resulting in death) A Narcotic Intoxication Due to (or as a consequence of			Death
		or condition resulting in death) Due to (or as a consequence of):		
	7	Sequentially list conditions, if any, leading to immediate D. Due to (or as a consequence of	<i>.</i>		
	miner	cause. Enter Underlying Cause	<i>P</i> .		
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a a e	lical	UNPENDED AMENDED			
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Box 68760, death certificate be the attending physic defor use as the bur	lu/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna		Month Day Year
x 6 th cer tendi	icis	Pregnant at time of de	ath 5 Other (Specify)		
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res that the signed by	d b			1 Yes 2	No 3 Probably 4 ✔ Unknown
ords, I	Completed		_	24a. Was an	24b. Were autopsy findings available
cords law requi	ğ			autopsy performed	prior to completion of cause of death?
Rec The I icate I page	Ö			1 Y Yes 2	No 1 Yes 2 No
Vital Recysician: The his certificate director, page	Be (25. Was case referred to medical examiner?	26.Place of Death (Check of		
de Bi 35 ≤	0	1 Yes 2 No No Inpatient 2			dence 6 Other: Scene
n of \ding Ph After tl	l:	27. Manner of Death 1 Natural 5 Rending FOUND: Day. Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how in Unknown	njury occurred
ion tendi eath. for: /	ţ	Feliding Amp F 2000	FOUND: 1	Olikilowii	
/iSi r Att her de irecta	fica	Z Moddolk Mitodigation	ome, farm, street, factory, office building, etc.		t and Number or Rural Route Number, City
Div ital o	Certification:	4 Homicide determined (Specify) Single Fam	nily	or Town, State) 3903 73rd Avenue	e, Hyattsville, MD
Tospi 4 hou uner		29a. Certifier 1 Certifying Physicians To the heat of my knowled		due to the cause(s)	and manner as stated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	one) 2 Medical Examiner:On the basis of examination a			
To t To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
,	_		O.C.M.E.		
		Court Hallan	U.C.M.E.	Ap	oril 6, 2009
6	1	30. Name and address of person who completed cause of death (Item	•		
7	05 18		111 Penn Street, Baltimore, MD 2120	1	
S	tate	31. Data PRM ntryD2009 (20032 Registra) Signar	rack		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. 2 0 0 0 1 1 1										11100	
		1. Decedent's Name (First, Middle, Last)						Reg. No. 2. Date of Death 3. Time of Death			3. Time of Death
	Physici /Medio		Robert Lyman Hickok, Jr.					Month April	Day 15	Year 2009	3:25 pM
20	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea					h	4c. County	of Death	
Shady Grove Hospit							Rockville				gomery
ı.	Funeral		5. Social Security Number 6. Sex	M 2□ F 7. Age	e (In yrs. last birthda Yrs.	/) If Under 1 Ye Months Da		(Month, Da	, Year)	Coun	
	Director		095-20-2573 Usual Residence of Decedent		80 YTS.			February	25,1929		New York
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the moderal Evan than a use the rediffical at	ctor	10a. State 10b. County		10c. City, Town or I	ocation				10	Od. Inside City Limits
			Maryland Montgomery H				Potomac	Potomac			
		Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
			1701 Glastonberry Road			20854				U.S.A	
	items	Funeral	The Marian States	2. Was Decedent I Armed Forces?		. Was Decedent If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Rad Bla	ce - Americ ck, White, e	
36	rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 🐼 N If Yes, Give Year or Dates:	10	1 □ Yes 2 🗷 I	No Specify:		Specif	y:	White
21215-0036	2 hou	ted	15. Decedent's Education			16a. Decedent's Usual Occupation			16b. Kind of Business/Industry		
215	e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)					
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<u>\ </u>	2 should be and Menta is marked raumatic ev	ပ္	Robert Lyman H						William		
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Typ	,		,	eet and Number or Ru				Code)
<u>ရ</u> ်	1 and 2 Health em 27 i		Robert L. Hickok, III - 20a. Method of Disposition	Son	20b. Place of Disp		et, Mullica	Date New	Jersey (wn. State
no	ages ant of t: If it		1 ■ Burial 2 □ Cremation 3 ■ Re	moval from State	cemetery, cr	ematory or other	olace)				
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	- 74	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	7	Memory's	Garden 22. Name and Ad		22/2009	Schenect	ady, N	ew York
Ba	Dep Imp any		Namas A X		1	Hines-Rina	ldi Funeral	Home, Inc.	er Sprin	. Mary	71 and 20904
F			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailings. List only one cause on each line. Approximate interval Between								
	Physician		Immediate Cause (Final disease or condition Acute Renal Failure							Onset and Dea Days	
	/Medical Examiner		resulting in death)	:			_				
		-	Sequentially list conditions, if any, leading to immediate	Liver Failur a consequence of):					Days		
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	ertifica ing ph e as th	Med	IF FEMALE:						-1	-	
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	ne de the a hed fe	/sic	1 □Yes 2 □No 9 □ Unknown	time of death 5							
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<u> </u>	Physici this cer al direc		examiner? 1 ☐ Yes 2 🙀 No	spital: 1 🕱 Inpatie	nt 2 🗆 ER/Outpati	ent 3 🗆 DOA	Othor:	lome 5 ☐ Resid		ner <i>(Specif</i> i	<i>(</i>)
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<u> </u>	Attendil death. ctor: A y the fu	catic	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Sulcide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
DIVISION OF	or Atl fter d Sirect in by	Certification: To								l Route Number,	
	pital burs a eral [29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								tated
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours affect eteath. Within 24 hours affect eteath. Gompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)	er: On the basis of	examination and/or	investigation, in r	ny opinion, death occu	urred at the time.	date and place.	and due to	the cause(s)
	Vithin To the comp	Me	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
	15		* ACTIN	1 M	1).	Do	065/3	32 APRIL 15, 2009 Les Drive Rockville, 20850			
	1		30. Name and address of person who con	pleted cause of de	eath (Item 23a) (Type	, Print)	0 0 1	^ .		1 *1	,
	Sta	to	WEI ZH/-ING 31. Date filed (Month, Day, Year)	32 Registra	- 9901 N	eledica	& Cente	v Driv	e, Koc	Kvil	le, 20850
	Sta Registr		APR 17 200	9 Deneu	N. 19	arks					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sheila Deborah Hooks April 9, 2009 8:39 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton <u> 7904 Clendinnen Dr.</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 😽 F 57 579-70-2510 Director 1952 8, Washington, D.C. Feb. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show event, the Medical Evaminar must be notified at 1X Yes 2 □ No Directo D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20019 108 -50th Street N.E. items 23a United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ₺ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than ' other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Thelma Jackson Charles Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7904 Clendinnen Dr. Clinton, Md. 20735 Anthony Hooks / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/15/2009 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. Metropolitan 22. Name and Address of Facility
Alexander S. Pope.
5538 Mariboro Pike/Prorestville, MD. 21. Signature of Funeral Service Licenses 20747 stune 401085 23a. Part 1. Ther the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEAD & NECK CANCER **YEARS** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed ysician and e burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical phys the t attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🔀 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate ha 1 □Yes 2 No 1 ☐ Yes 2√No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dther (Specify) 1 Yes 2 XNo Medical Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ans. APRIL 15, 2009 D0041119 10 0 SILVER SPRING, MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 DAYA S. SHARMA, M.D. 1400 FOREST GLENN ROAD, SUIT #435

Registrar
DHMH 17 Rev 1/2001

State

APR 1 7 2009

A. pares

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary					0000	11100	
			Registrar 1 Decedent's Name (First Middle, Last) 2. Date of Death						3. Time of Death	
	Physicia: /Medica		HASSAN IZADI April 12 2009							
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death Montgome		
			Suburban Hospital 5. Social Security Number 6. Sex 7. Age (Ir.	(In yrs. last birthday) If Under 1 Year			8. Date of Birth (Month, Day			
	Funeral Director		1M 4 0 =	78 Yrs.	Months Days	Hours Min.	(Month, Day, 1) 4/22/1	.930 Co.	untry) Iran	
			Usual Residence of Decedent						404 Inside Oits I finite	
	rylane how	_	Tour State	c. City, Town or Lo	_				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	e Ma 3a-f s	Director	MD Montgomery			tomac		0	••	
	ith th		10e. Street and Number		10f. Zip Code	2005/	10(g. Citizen of What Co		
	s 23a	Funeral	10718 Rock Run Drive		Was Decedent of H	20854	cify Yes or No-	U.S		
	item item	Ĕ.	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Series Armed Forces Series 1 Never Married 2 Married			ispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)	Black, White	e, etc.	
336	al", or	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □Yes 2 🛣 No	Specify:		Specify: Whi	.te	
<u>-0</u>	2 hot	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decer	dent's Usual Occup	ation	na 1	6b. Kind of Business/	Industry	
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21	ed wij	So	5+		Dipl	18. Mother's Name	/First Middle M	Governmen	t of Iran	
E L	be file at oth even	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	,	ar Salehi		
Z S	d Mer narke	ဥ	Sadegh Izadi	10h Mailiu	na Addrass (Straat	and Number or Bura		City or Town, State, 2	Zip Code)	
M Ma	d 2 st th an 7 Is r traur		19a. Informant's Name/Relationship (Type. Print) Iradge Izadi (son)	190. Maili	-			Maryland 20		
é,	1 and Heal tem 2 other			20b. Place of Dispo	sition (Name of	D		0c. Location - City or		
Ιομ	ages ent of it: If it		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place emorial Part		/2009	Fairfax.	Virginia	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wedferd Experiment to modified a once.		21. Signature of Fun- al Service Licensee		2. Name and Addre					
ñ	Dep any		Margailasum Kune Murphy Falls Church Funeral Home, 1102 W. Broad St., FC, Va.							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between							
1	Physician		Immediate Cause (Final disease or condition	water	o pn	cuncy	ia	1	Onset and Death	
	/Medical		resulting in death) Due to (or as a consequence of):							
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687	tificat g phy as the	ledic								
09 Box	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)						23d. Date of delivery Month Day Year	
2/c	deat ne att	sicia								
//7 P.O	at the	Phys	9 Li Unknown	-titing in the I	undarbilee eeuee eis	on in Port I	23e Did tob	acco use contribute t	o the cause of death?	
y 8,	e law requires that the death certifi has been signed by the attending e 2 should be detached for use as	2	Part II. Other significant conditions contributing to death but n	ot resulting in the u	indenying cause gr	renni Faiti.	1 □ Ye		Probably 4 ☐ Unknown	
ASSAN L	The law requires ate has been sign page 2 should be	Completed								
3ec	e law has b e 2 sl	ם					24a. Was ar autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of	
S a	ician: The certificate ector, pag					00 Dis. (David	1 ☐ Yes 2	No 1 □Ye	s 2 🔊 No	
₹ Z	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 X ER/Outpatie	ont 3 🗆 DOA Otl	26. Place of Death		nce 6 Other (Sp	ecify)	
7.4	Physer this eral di	岸	27. Manner of Death 28a. Date of Injury	28b. Time o				w injury occurred		
48	ttending F death. tor: After the funera	aţioi	1 Matural 5 Pending (Month, Day, Y. 2 Accident investigation	(ear) Injury		Yes 2□No				
AD vis	or Attendatter deatt Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, st	treet, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	Rural Route Number,	
20	ital or rs after al Dir	Ce	0					(2)		
1-1	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ical	29a. Certifier (Check only (Ch	xamination and/or i	ith occurred at the t investigation, in my	ime, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manner a ate and place, and du	as stated. te to the cause(s)	
,	To the h within 24 To the F complet	Medical	one) and manner stated	d.	20o Licon	se number	2	9d Date signed (Mor.	nth. Dav. Year)	
			1	VV	Da	00624	35	4/13/	2009	
	3		30. Name and address of person who completed cause of deal	th (Item 23a) (Type	, Print) /	0 0	2 1	11 445	2000	
	(6X)		30. Name and address of person who completed cause of deal SAYENE(SAYAD) 31. Date filed (Month, Day, Year) 32. Registrar's	10110 1	Malelal	ar by.	VOCT-	ville vil	10050	
	Sta	ate		Signature	,					
	Regist	rar	APR 2 0 2009 Queen B.	gare	-			_		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State	Pleas	se Type or P State of		d / Dep		of H	lealth and N	lental Hy		220	11.109
		Registrar 1. Decedent's Name	e (First Middle	(ast)		06	Timeate	, OI L		2. Date of Dea		. 0 0)	3. Time of Death
Physicia				,						Month April	Day Year 15, 2009 9:00A. M		
/Medic Examin		Frances 4a. Facility Name (give street and num	ber)		4b. City, T	own, or	Location of Death	April		unty of Death	
Examin	eı			and Hospit			Clint	ton			Prince George's		
Funeral		5. Social Security N		6. Sex	7. Age (In yrs.	last birthday,	If Under		If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	h	9. Birth	place (State or Foreign
Director		229-28-02		1 □ M 20X F	8	O Yrs.	Monard		7,104,10	09/02/1	1928		VA
and w		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	ty, Town or Le	ocation						10d. Inside City Limits
Aaryla f sho	ō		ŕ	G 1 -									1⊠Yes 2□No
the A	Director	MD 10e. Street and Nu		George's	01	inton	10f. Zip	Code			10g. Citizer	n of What Cou	ntry?
3a or	Ö	7817 Den	ston Dri	77.0			20	735				USA	
ms 2	Funeral	11. Marital Status	ILOH DIT	12. Was Deced	dent Ever in U	.S. 13.	Was Decede	ent of Hi	ispanic Origin? (Sp	pecify Yes or No	- 14.	ican Indian,	
after or ite		1 Never Marr	ried 2 Marrie	Armed Ford 1 □ Yes If Yes, Give	2 ∑ No		1 ☐Yes 2		n, Mexican, Puerto Specify:	riican, etc.,	6.	etc.	
ours rral",	d by	3 🛣 Widowed	4 Divorced	Year or Da								pecify: B1a	
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within ene. than	ш	Elementary/Seco	ondary (0-12)	College (1-	4or 5+)		coll C		<i>'</i>		Comm	ınicati	Lon
filed \ Hygid ther		12 17. Father's Name	(First, Middle, L	ast)		1491	OII O		18. Mother's Nam	e (First, Middle,	Maiden Su	ma <i>me</i>)	
d be ental ked c	To Be	Frank Mo	oran				Loretta Morris						
shou ind M is mar umat	-	19a. Informant's N		ip (Type. Print)		19b. Mail	ing Address	(Street	and Number or Ru		er, City or T	own, State, Zi	ip Code)
alth a		Charles 1	Moran/So	on		7817	7 Dent	on I	Orive, Cl	inton,	MD 20	0748	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medeal Event incl. List be intiffied at once.		20a. Method of Dis	•	0 D D	20b. I	Place of Disp cemetery, cre	osition (Namematory or ot	e of her plac	e)	Date	20c. Loca	tion - City or T	own, State
Page ment ant: It			5 ☐ Other (Sp	3 □ Removal from S ecify)		incoln	Memor	ial	04/20	0/2009	Suitl	and, M	D
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/Medical Examiner		roodiang in dodan,		Due to (or as a consec	quence of):							
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the a	sic	1 ☐ Yes 21 9 ☐ Unknown	₩ No	4 ☐ Pregn	ant at time of own	death 5	Other (sp.	ecify)					
w requires that the dispersion is been signed by the should be detached				ns contributing to de	ath but not res	sulting in the	underlying ca	use giv	en in Part I.	23e. Did 1	tobacco use	contribute to	the cause of death?
uires n sign ld be	d by									1 🗆	Yes 3	No 3□ Pro	obably 4 ☐ Unknown
w req	lete									24a. Was	an	24b. Were au	topsy findings available
he lay e has age 2	Completed								· · · · · · · · · · · · · · · · · · ·	auto perfo	psy ormed?	prior to death?	completion of cause of
an: T tifficat or, pe	a	25. Was case refe	rred to medical				-		26. Place of Dea	1 ☐ Yes	No No	1 Ll Yes	2 🗆 No
ysici is cer direct	To B	examiner? 1 ∐ Yes 2 😼	I No	Hospital: 1 □ I	npatient 2	LER/Outpatie	ent 3 DO	A Oth	or:	ome 5 Res		Other (Spec	cify)
ig Ph ter th neral	T:U	27. Manner of Dea	th 5 Pending	28a. Date o	of Injury h, Day, Year)	28b. Time Injury	of 2	8c. Injur Worl	y at k?	28d. Describe	how injury o	occurred	
endir sath. or: Af he fur	atic	1 Natural 2 Accident	investig	ation			М		Yes 2□No				
r Att ter de irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	I 28e. Place	of Injury - At h ng, etc. <i>(Spe</i> c	nome, farm, s ify)	treet, factory	office		28f. Location (City or To	Street and i wn, State)	Number or Ru	ral Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)	2 Medical I	g Physician: To the Examiner: On the ba and mann	asis of examin	ation and/or	investigation.	in my o	opinion, death occu	irred at the time.	date and p	lace, and due	to the cause(s)
orthe	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) 29d. Date signed (Month) 29d. Date signed (Month) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William I ANNEL an 11701 Civings on Rond Fort WARHINGT. 31. Date filed (Month, Day, Year) APR 20 2009 Security 3. Registrar's Signature APR 20 2009									n, Day, Year)		
4		> Well	Via 1	Greek			1	03	5206		As	.116	2009
/			ress of person	who completed caus	e of death (Ite	m 23a) (Type	e, Print)		1 0	1 0			/
ax			liam	1, TANNE	or an	le	ul Lis	ing	som 1800	t to	rwa	stingt.	and Lasta in
Sta		31. Date filed (Mor	nth, Day, Year) 0 2009	32. R	egistrar's Sign	ature		-				,	
Registr	dl	120 17 6		Marine &	1. 1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ARTHUR JACKSON 20:49 P M THOMAS 2009 APRII /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-25-1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **№**2 M 2 🗆 F 231-22-8941 81 **Director** VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Evantant is recitified an once. Director 1☐Yes 2☐No WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 UNDERWOOD STREET N.W. 20012 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 2006

If Yes, Give Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No ģ Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) L.F. JENNINGS COMPANY 12th BRICKMASON 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) **JACKSON** FANNIE **JAMES** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4813 LAKEVIEW LANE BOWIE, MARYLAND 20720 STEPHEN JACKSON/ SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Jurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-18-2009 MARYLAND NATIONAL LAUREL, MARYLAND Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 1005 12th STREET N.E. WASHINGTON, DC 20017 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each lin Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a pinse quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 | Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No P.O. 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Johknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Ves 2 No 1 □Yes Be 25. Was case referred to mical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No Director: 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2.

State Registrar 29b. Signature and title of certifier

NASREEN

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print)

7701 32. Registrar's Signature

DHMH 17 Rev 1/2001

2

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 20, Day 009 Physician 0230 A M Pearl M. Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Country View Assisted Living Darlington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-24-4644 Days Hours Min. Delaware 1 □ M 2 💢 F 81 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 X No Director Havre de Grace Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States of America 325 Darlington Road 21078 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23 any injury or other traumatic event, the Medical Examinat must any injury or other traumatic event, the Medical Examinat must any olice. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No Specify: 3 X Widowed 4 □ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Computer Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Shirley Shuster Frederick Stierle 19a. Informant's Name/Relationship (Type, Print) Gwendelyn Liebig (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 DarlingtonRd. Havre de Grace, MD 21078 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns 104-27-2009 Bel Air. Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. of Faneral Service Li 123 South Washington St. Havre de Grace, MD 21078 23a. Part 1. Enter the disease shock, or heart failure. L , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumoni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Malnus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cautilities is doubt), act Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Valvular resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 □ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1003 30. Name and address of person who completed, cause of death (Item 23a) (Type, Print) 21014 Dove resupea

State Registrar 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Gerald P. Sterner, MD,

Lewis

31. Date filed (Month, Day, Year)

APR 20 2009

ORIGINAL

32. Registrar's Signature

D. parks

19 Ches. Beach Rd. E., Owings, MD 20736

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

0237

1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

weeks

Day

20678

Physician /Medical Examine

Baltimore, Maryland 21215-0036

Box 68760

Division or Vital Records, P.O.

law requires that the death certificate be executed attending phase as t signed by the a d be detached f has page 2 s After this certificate I r Attending Physician: ofter death. 24 hours after deat e Funeral Director Hospital within 2

Month Day Year **Physician** Kalen 2009 Anna 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Day, Day) 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🕅 F 07/26/1920 Director 077-09-4855 88 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 1ry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Chesapeake Beach MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20732 3402 Hillside Place Completed by Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cook nursing home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmella Gianntonio Temperio Pasquale ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3402 Hillside Pl., Chesapeake Beach, MD Pasquale J. Morrone, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/14/2009 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lice 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hillure. List only one cause on each line. Immediate Caus (Ei al Heart resulting in death) Due to (or as a consequence of): chona Sequentially list conditions, Teny Lading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of): Examiner 50p820 physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 NO 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061783

State Registrar

DHMH 17 Rev 1/2001

100 Hospital Road, Prince Frederick, MD

barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14 2009

32. Registrar's Signature

Chang Choi, M.D.

APR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 1:15 Margery Mary Komecki April 7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Nursing Home Berlin 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 🛣 F Months Days Hours 30, 1918 Director 128-03-4197 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, Inc. Modical Examination must be notified at 1 ☐ Yes 2 TNo Director Ocean Pines Maryland Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a any injury or other traumatic event, II.s. Menters. 21811 U.S.A. 82 Newport Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕱 No Specify Completed by Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Realty Company Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Cullen Thomas Hynes ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 82 Newport Drive, Ocean Pines, MD 21811 Casey Angelino / niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/09 Toms River, NJ Calvary Cemt. 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 Williams Street, Berlin, Maryland 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 12 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Natural To the Hospita, ... within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 041 D 63199

P.0 Division of Vital Records,

Box 68760,

Komecki, Margery Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, Year) Registra 2009

LOGESH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHFA

614 EAST ERN

Registrar's Signature 32.

SALISBURY MD 21804

09-03262 Kirk Kinsev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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II IX	ranscy		- For State Control of Certificate C	of Death	Reg. No.				
	Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 1135 hrs			
/lec	dical Exami	ner	Kirk Kinsey		Month Day April 23, 2009				
1		Ш	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death Talbot			
			205 Cherry Street	St. Michaels		WDD/YYYY) 9. Birthplace (State or Foreign			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	-	Country)			
	Director		218-66-3663 1XM 2 F 54 Y1		AUG. 23,	1954 DC			
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	otion		10d. Inside City Limits			
	w any		Total State	ation		1 X Yes 2 No			
	daryland 28a-f show 1 at once.	ġ.	Maryland Anne Arundel Annapolis	10f. Zip Code	10g. Git	tizen of What Country?			
	Mary r 28a- ed at	5	10e. Street and Number	21403	ľ	ted States			
7	th the 23a o		12 Melrob Court Apt. #102 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (Sp		14. Race - American Indian, Black,			
K	215-0036 be filed within 72 hours after death with the Maryland mail Hyggiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral Director	1 Never Married 2 X Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto		White, etc.			
	er dez		Widowed 4 Divorced If Yes, Give Year 1972–1975		Specify: White				
	ural'	<u>a</u>	15 Decedent's Education (Specify only highest grade completed) 16a, Decede	ent's Usual Occupation (Give kind of w most of working life. DO NOT use retir	ork done 16b.	. Kind of Business/Industry			
	2 hot	돯	Elementary/Secondary (0-12) College (1-4 or 5+)						
	036 thin ne.	Completed	1 Real	Estate Agent		Real Estate			
	5-0 led wi Tygie other	ड	17. Father's Name (First, Middle, Last)		(First, Middle, Maide				
	21215-0036 Duld be filed within 7 I Mental Hygiene, i marked other than ic event, the Medica	Be	Raymond McKinley Kinsey	Ing Address (Street and Number or F	a Ann John				
	timore, MD 21. it. Pages 1 and 2 should be riment of Health and Men retant: If item 27 is mary yor other traumatic eve	유		elrob Court Apt.					
	MD and 2 sho alth and sim 27 is raumati	-		osition (Name of cemetery,	Date 200	c. Location - City or Town, State			
	of He		1 Burial 2 X Cremation 3 Removal from State crematory or	other place) AP	R. 28,	Namuland			
	Lim Pag Iment tant:	1	4 Donation 5 Other Specify.	c Crematory 20 Name and Address of Facility		Glen Burnie, Maryland			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiette. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Thum M Thu M01508	hibadeau Mortuary 33 Gist Ave., LL,	Service.	P.A. pring, MD 20910			
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	or the mode of dying, such as cardiac c	or respiratory arrest, s	shock, or heart Approximate Interval Between Onset and			
	/Medical		failure. List only one cause on each line.			Death			
	kaminer		Immediate Cause (Final disease or condition resulting in death) a. Methadole filloxical functions as a consequence of):						
			Sequentially list conditions, b.						
		iner	if any, leading to immediate Due to (or as a consequence of):						
		Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		-				
	cuted nd transit		4	MD 001 F/F/	20 mm				
	Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	XUNPENDED AMENDED 23a,27,28a-1	perME, g891 5/5/0)9 TT				
	760, cate be physic he bur		IF FEMALE: 23c. If yes, outcome of pregnancy	2		23d. Date of delivery Month Day Year			
	68 certifi ding se as	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn. Other (Specify)	aricy	Month Day Year			
	SOX leath e atter for u	Physician/	1 Yes 2 No 9 Unknown g Unknown	Other (opecity)					
	D. E. trhe of by the ached		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the cause of death?			
	P.(es that igned be det	d by			1 Yes 2	No 3 Probably 4 Unknown			
	rds, requir	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
	e law e has ge 2 sl	ᇤ			performed 1 ✓ Yes 2	d? death? No 1 ✔ Yes 2 No			
	Refired tifficat	ပိ	25. Was case referred to medical						
	/ita /sicia nis cer direct	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other Nursi	ing Home 5 Res	sidence 6 Other: Scene			
	Division of Vital Records, P.O. Box 687 ral or Attending Physician: The law requires that the death certificate and death. 31 Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Ĕ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		28d. Describe how	injury occurred			
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	VISI or Att fter de Direct in by	≝	28e. Place of Injury - At home, farm, s	street, factory, office building, etc. Breakfast	28f. Location (Stree or Town, State	et and Number or Rural Route Number, City 205 Cherry St.			
	Dipital of ours a ceral I	Certification:	4 Homicide determined (Specify)		St. Micha	nels, MD			
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Sal (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner:On the basis of examination and/or invest) and manner as stated. I place, and due to the cause(s)					
	To th withir To th	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (a						
		≥	Zep. Signature and title of certifier	O.C.M.E.		April 24, 2009			
	1+1		lard Hellan	J. J					
			30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 212	01				
	-	tate							
	Regi		ATT NO LOUD LENGTH D. Z	backs					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month ^{Day} 2009 Physician April 8:30 15, AMGeorge Frederick Kettle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 10831 Lockland Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 22, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Washington D.C. 1 X M 2 □ F 1928 Director 578-34-6861 80 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2X No Funeral Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 10831 Lockland Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -2-Real Estate Broker Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Ewing Frederick Kettle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice C. Kettle – Spouse 10831 Lockland Road Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Apr. 19, 2008 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Jefferson Funeral Chapel 21. Sign Jura of Funeral Service Licensee 5755 Castlewellan Dr. Alexandria, VA 22315 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ause (Final Isease or condition resulting in death) **Physician** DIMUNAL andro Days /Medical Due to (or as a consequence of): **Examiner** hymric career Meta Static Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To the Hospital or Autonomy Within 24 hours after death.

To the Funeral Director: After this ce Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertify g hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medi at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) 0101055606 VA

State

Registrar APR 17

31. Date filed (Month, Day, Year)

32 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mason Dr. # 307 Arly ton VA 22205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Mary Alice Kibler April 11 2009 0030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3316 Sykesville Road Westminster Carrol 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Director 213-60-0207 Jan 10 1915 MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3316 Sykesville Road 21157 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas W. Gist Mamie A. Loque ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. 3316 Sykesville Road Westminster, MD Ervan Kibler/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Park UMC Cemetery 4/15/2009 4 ☐ Donation 5 ☐ Other (Specify) Smallwood, MD 21. Signature of Funeral Service Licensee 2PMTERS AFTIMEFRITY Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe mitral RAURAITATION Physician LICAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ severe tricupid reguzaitation 2 XNo 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Breast Chucer 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No P 27. Manner of Death 1 2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

that the death certificate be executed burial-tran Box 68760, physician the as attending for use P.O. ed by the a detached f signed t Division or Vital Records, page 2 should certificate has I or Attending

r 28a-f show notified at

o e

"natural", or items fedical Examiner m

the Medical

2 should be filed within 72 hours after death with t and Mental Hygiene.

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

After this

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

3 Suicide

4 Homicide

Homes K. (salve in

29c. License number D31660 29d. Date signed (Month, Day, Year)

MARYLAND

24157

04/13/2009

WESTMWSTER

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS K. GAWWIII ma 291 STONEL AVENCE

31. Date filed (Month, Day, Year) APR 14

6 Could not be determined

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. _ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Kline Beverly Romaine **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 34/15bury HICOMIO egIONAL TENINSULA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Funeral Days Hours Min 1 □ M 2 🗙 F 217-42-8900 02/09/1942 Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Actical Examinating the notified at 1 X Yes 2 □ No Salisbury Wicomico Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 400 Park Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 XNo white Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, Item In College (1-4or 5+) secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Belle Staub Franklin Leroy Hann, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
400 Park Ave., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Trevis M. Keefer/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/20/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ovice H. Won 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Compoor arric 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NEMMINIC /Medical Due to (or as a consequence of) Examiner 17138 KIN Sequentially list conditions, if any leading to manage cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2 No detached g Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 ☐ Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Alatural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Mon

State Registrar StEVEN

31. Date filed (Month, Day, Year)

St. SAlisbury Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

HEARNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** 9:50 AM APRIL 13, ANDREW KILPATRICK, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SILVER SPRING HOSPITAL CROSS HOLY If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Hours Director 241-62-5510 64 January29,1945Kinston, N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic every ev 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1x Yes 2 No Directo PRINCE GEORGE'S Maryland CAPITOL HEIGHTS 10g. Citizen of What Country? 10e, Street and Numbe 9405 BEECH PARK UNITED STREET 20743 STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 -0-ENTREPRENUER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY ROUSE ANDREW KILPATRICK, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9512 SHERWOOD Dr., Upper Marlboro, MD. 20772 KILPATRICK-WIFE MARIAN 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1
☐ Burial 2 ☐ Cremation 3 Removal from State Heritage Memorial PK. 04-17-09 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5538 Marlboro Pike MO098/ POPE FUNERAL HOMES, PA. Forestville, MD. 20747 your 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BOWEL OBSTRUCTION a. SMALL disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner STAGE RENAL DISEASE b. END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CARDIOMYOPATHY resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been significate has page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate 1 ☐ Yes 2 🕅 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🌠 No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death To the Hospital or Attending Pleath.
within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20056067 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B 20910 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND **KANWALJIO** \mathtt{MD} . NAGI,

Registrar
DHMH 17 Rev 1/2001

State

32. Rg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nark Amed Lewis	1	SIBIE - For State Registrar	e of Maryland /		rtment of He tificate of De		iu iviental H		leg. No.	20	09 1412	
Physicia Medical Examin	n/	Decedent's Name (First, Middle,La		i a	-			2. Date of Dea Month April 7, 20	ith	Year	3. Time of Death 1437 hrs	
weunear =xamin ∕		Mark A 4a. Facility Name (if not institution, g	Ifred Lew ive street and number)	1S	4b. C	ity, Town, o	r Location of Death			ounty of Death		
		Calvert Memorial Hospita				ince Free		In - :		lvert	**	
Funeral Director		219-84-6980	Sex 7. Age	(In yrs. Ia		Under 1 Yea			,	Foreig	thplace (State or gn MD)	
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location						10d. Inside City Limits	
Maryland 28a-f show d at once.	اق	MD Anne A	rundel				Beach				1 Yes 2 X No	
ith the Maryland 23a or 28a-f sho notified at ouce.	Director	10e. Street and Number			10	f. Zip Code 207	1 /		10g. Citizen of What Country? USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		7005 Albany Ave	12. Was Decedent I	Ever in U.S		cedent of H	ispanic Origin? (S				ican Indian, Black,	
or death	Funeral	1 Never Married 2 X Marrie	1 Yes 2	No		2 X N	n, Mexican, Puerto	Rican, etc.)	6.	pecify: wh:	ite	
urs afte	<u>م</u>	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates: only highest grade com	pleted)	16a. Decedent's U	sual Occupa	ation (Give kind of			d of Business/		
ical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)			e. DO NOT use ret	ired)		nataus	tion	
d withi	탉	12 17. Father's Name (First, Middle, Las	et)		glazie		18.Mother's Nam	e (First, Middle,		nstruc urname)	1011	
1215 1 be file ental H nrked o	a	Clarence Scot				_	Martha			evens		
L Shoule 1 and M 27 is m	2	19a. Informant's Name/Relationship Elizabeth B. Le	, , ,	<u>,</u>			eet and Number or Avenue,					
re, N L and S Health Fitem	ŀ	20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. F	Place of Disposition crematory or other p	(Name of co		Date		cation - City o		
Pages ment of taut: I	L	4 Donation 5 Other Specia	fy:	i.e	ropolita	n Crem						
Balt permit Depart Impor injury	H	21. Signature of Funeral Service Lice William R	m	usch Fu Lane, C	wings	s, MD 2						
Physician /Medical	24	23a. Part I. Enter the disease, or confailure. List only one cause on	each line.	the death.	. Do not enter the m	ode of dying	g, such as cardiac	or respiratory ar	rrest, shock	k, or heart	Approximate Interval Between Onset and Death	
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Hanging Due to (or as a conse	quence of	f):				_		- Journ	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	guence of	Th:							
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cuted md transit	Ë	events resulting in death) Last	d									
60, ate be exe hysician a	Medical	UNPENDED	AMENDED						-			
iox 68760, cath certificate be executed a attending physician and for use as the burial - transit	W/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregr	nancy 2 Fetal d	eath 3	Ectopic pregr	ancy		Date of delive Month	ry Day Year	
Box 687 death certific the attending p ed for use as th	Physician/I	1 Yes 2 No 9 Unknow	4 Pregnant at	time of de	ath 5 Other	(Specify)						
that the d		Part II. Other significant conditions	The state of the s	but not re	esulting in the unde	rlying cause	given in Part I.				the cause of death?	
S, P.C uires that in signed I	ed by		-								obably 4 Unknown	
cords law requi	Completed								opsy formed?		completion of cause of	
ital Rec ician: The s certificate rector, page		25. Was case referred to medical			-	26.Plac	ce of Death (Check		2 V No	1 \	res 2 No	
Vita hysician this cer	Ö	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient 3	DOA	Othor:	ing Home 5	Residen	ce 6 Oth	er:	
Ing P	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day, Y Apr 7, 2009	ry ear)	28b. Time of Injury 0000 hrs	1 _	jury at Work? Yes 2 ✔ No	28d. Describe Subject ha				
Divisior Hospital or Attent 24 hours after death Finneral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not	ation 28e Place of In		ome, farm, street, fa					d Number or F	Rural Route Number, City	
Divis spital or At tours after d neral Direct filled in by	Certi	4 Homicide determin			1	Avenue,	North Beach					
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier 1 Certifying Phys one) 2 Medical Examin	ician: To the best of my er:On the basis of exar	/ knowledo nination a	ge, death occurred nd/or investigation,	at the time, in my opinio	date and place, ar on, death occurred	d due to the car at the time, dat	us e(s) a nd e and plac	manner as sta e, and due to	ated. the cause(s)	
To the within To the compl	Mec	29b. Signature and title of certifier	and manner stated.		*	29c. Licer	nse number		29d. D	ate signed (M	onth, Day, Year)	
		Numun	— IMD	_		0.0	C.M.E.		April	8, 2009		
Ril 10		 Name and address of person wh Donna M. Vincenti, MD 	o completed cause of d Assistant Medic			enn Stree	et, Baltimore, I	MD 21201				
Sta	ate	31. Date filed (Month, Day Year)	2009 32. Registra	's Signatu								
Regist	rar	APR 14	UIII plene	way .	G. Joan	All water						

	_1	For State Registrar		Marylar	•	artmen rtificate					Reg. No. 2	009	14122	
Physician		 Decedent's Name (First, Middle Mary Margaret La 							2	2. Date of Dea Month April	ath 12. 200	Year	3. Time of Death 11:15p ^M	
/Medical Examiner		4a. Facility Name (If not institution 14503 Westbury R	oad	,			Roc	ocation of	Э		4c. Cc	ounty of Deat Ion toome	h ry	
Funeral Director	1	5. Social Security Number 577–36–3411	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.	79 Yrs.	If Under Months	Days Days	Hours	Min.	8. Date of Birt (Month, Da ecember	h y, <i>Year)</i> 18, 1 9	Co	hplace (State or Foreign untry) DC	
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
vith the Mary	5	MD Mont	gomery		Rock	ville						1 ☐Yes 2 💆 No		
with th		10e. Street and Number 14503 Westbury Ro	ad			10f. Zip	Code 20853				10g. Citize	n of What Co USA	untry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Marical Eventing must be notified at once. To Re Completed by Europea Director	2	11. Marital Status 1 □ Never Married ②XX Marri 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	ces? 2 XX No re		Was Deced fYes, spec 1 □Yes 2		panic Orig , Mexican, Specify:	gin? (Spec , Puerto R	cify Yes or No- ican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hyglene. 27 Is marked other than "natural", or traumatic event, the Medical Event, To Re Commissed by E	ou bieter	15. Decedent (Specify only highes Elementary/Secondary (0-12) 10	's Education t grade completed) College (1	-4or 5+)	(Give	dent's Usua kind of wor DO NOT us C lerk	l Occupat k done du e retired)	tion uring most	of working	9		of Business/	Industry	
yland 2 wid be filed Mental Hygi arked other attic event,	ב ב	17. Father's Name (First, Middle, I				18. Mother's Name (First, Middle, Maiden Surname) Fannie L. Dolby								
Mary nd 2 shou alth and N 27 is mary trauman	2	19a. Informant's Name/Relationsh John F. Lawrence				•	1			Route Number	per, City or Town, State, Zip Code)			
Baltimore, Department of Hes Department of Hes Important: If item many injury or othe		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. i	Place of Dispo cemetery, cres cropolita	sition (Nam natory or ot an Cres	e of her place) atory		Da Oril 1	te 3, 2009		tion - City or tandria,		
Balti permit. Departn Importa any inju		21. Signature of Funeral Service L	icensee WWW	nej	22	Name and Franci	Address S J. (of Facility Collin	rs Fun	eral Hon	e Inc. ver Sp	oring, M	D 20901	
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on ea	aused the deat ach line. tastatic		er the mode						S 574	Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)		or as a conseq		I DOL								
executed an and ital-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):									
8760, cate be executed oblysician and the burial-transit dical Examin	Eva Eva	resulting in death) Last	juence of):	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)										
Box 6 auth certifii attending por use as	I)SICIAII/IMEGIC	Ily Silving in moure.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Live						230	d. Date of del Month	ivery Day Year			
rds, P.O. quires that the de n signed by the auld be detached the detached	2	Part II. Other significant condition Emphysema	ns contributing to de	ath but not res	ulting in the u	nderlying ca	use given	n in Part I.					the cause of death?	
of Vital Records, Physician: The law requires to this certificate has been signed all rector, page 2 should be completed by	The state of the s				- · · · ·	= 1 = 0	<u>.</u> .					24b. Were au prior to death? 1 ∐Yes	topsy findings available completion of cause of	
f Vital Rivstoian: The systoian: The lis certificate h director, page	3	25. Was case referred to medical examiner?	Hospital:				Othor			(Check only o	ne)			
on of oling Phys h. After this funeral dil		1 Yes	28a. Date of	npatient 2 of Injury h, Day, Year)	ER/Outpatier 28b. Time of Injury		Bc. Injury a Work?	4 ⊔ Nur	28	e 5XXResid 3d. Describe I			cify)	
Division of tal or Attending Physics after death. Tal Director: After this led in by the funeral director: To Certification: To Certification: To		3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	I ome, farm, str fy)	eet, factory,				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division To the Hospital or Attent within 24 hours after death within 24 hours after death or ompletely filled in by the Medical Certifical Medical Certifical			g Physician: To the Examiner: On the ba and mann	asis of examina										
To the comp		29b. Signature and title of certifier	dyran	ıl		290	License i	number 2452				signed (Monti 1 13, 20		
*	;	30. Name and address of person of Chitra Rajagopal	(/ 1/	e of death (Iter		,	lnos:	MD 30	เชรา					
State Registrar		31. Date filed (Month, Day, Year)		egistrar's Signa			ruey,	MD 40	034					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	-	Certificate of De		entai mygie Reg	0000	14123
Dhuniai		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Thelma Gladys Letts				April 19	2009	05:33 AM [™]
Examin	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County of Dear	th
		40 Fineburg Road 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birt	North Eas		8. Date of Birth	Cecil	thplace (State or Foreign
Funeral Director		220-03-7718 Usual Residence of Decedent			Hours Min.	(Month, Day, Y	(ear) Co	t Virginia
land ow		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Mary I-f sh	ţō	Maryland Cecil	Nort	h East				1 ∐Yes 2∛∭XNo
h the	Director	10e. Street and Number	NOIL	10f. Zip Code		10g	. Citizen of What Co	ountry?
th wit	'al [40 Fineburg Road		21901		τ	United Sta	ates
iges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Margal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ ▼ If Yes, Give Year or Dates:		13. Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 ☒ No	panic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
in 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired)	on ring most of workin	16	b. Kind of Business	/Industry
led withi		Elementary/Secondary (0-12) College (1-4or 5	+)	Accountant	Railr 18. Mother's Name (First, Middle, Maiden Surname)			d
intal Fed out	Be	17. Father's Name (First, Middle, Last)		18		(First, Middle, Ma Pearl Pai		
any jan	٩	Harry Fraley 19a. Informant's Name/Relationship (Type. Print)	10h	Mailing Address (Street and				Zin Code)
IVICA Ind 2 s Influen 27 is i		Bonnie Patrick / Adopted Granddaugh	- 1	Fineburg Roa			•	21901
permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tage.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1 20h Place of	Disposition (Name of y, crematory or other place) East Methodis Emetery	Di	I ^{te} 22,	c. Location - City or	
it. Partmei		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furegal Service Linences		22. Name and Address		1		, Maryland
Dentit. Departr Importa any Inju		21. Signating of State Control Control						ary1and21901
Physician /Medicai		23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)	the death. Do ne.	MELHON		r respiratory arres	t,	Approximate Interval Between Onset and Death
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ath cer attendir	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year				
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or Attending Physician: The law required redeath. Director: After this certificate has been s in by the funeral director, page 2 should live the control of	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
sian; ertific ctor, I	Be	25. Was case referred to medical examiner?			26. Place of Death			
hysik this c	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie		tpatient 3 DOA Other:	4 Li Nursing Hon		ce 6 ☐ Other (Spe	ecify)
nding F ath. r: After e funere	ation:	27. Manner of D ath 1		Time of 28c. Injury a 28c. In	at 2 s 2 □No	28d. Describe how	injury occurred	
al or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubiliding, etc	iry - At home, far c. (Specify)	rm, street, factory, office	2	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination an					
To the vithin To the comp	Me	29b. Signature and title of certifier	Ma	29c. License n	number	290	d. Date signed (Mon	th, Day, Year)
8		30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print)	park 4	16/1	1/20/	78
		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	Cus Di	704 1/C	The pull	1 2/01	٥
Sta Registr		APR 21 2009 June	A. A	barked				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 00 SANYA 1 Zeen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Joder 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, NOV 20, HARFORD 9. Birthplace (State or Foreign R PARK Security Number COURT 608 Age (In yrs. last birthday Months 1 M 2 KF MARYLAND 46 1962 Yrs 217-82-5210 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 □ No **EDGEWOOD HARFORD** MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21040 UNITED STATES 608 HARR PARK COURT 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. BLACK Specify: 3 ☐ Widowed 4 🎇 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD MANUFACTURE PRODUCTION WORKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BARBARA HOLLEY CHARLES LEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 LORELEY ROAD, WHITE MARSH, MARYLAND 21162 BARBARA HOLLEY-SMITH MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ASBURY CEMETERY 04/17/09 WHITE MARSH, MARYLAND 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, 21. Signature of Funeral Service Licensee P.A. xott-Coloman 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SARCOIDUSIS 10 YR Due to (or as a consequence of): TRANSPLANT VING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MZANS FLANT Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ₺No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If them 27 is marked other tha any Injury or other traumatic event, I'm. once.

event, the Medical Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar been signed by the should be detached page 2 s this c

certificate

After

within 24 hours aft

To the Funeral Di

completely filled in

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be Certification: To after death Director: / d in by the f

25. Was case referred to medical examiner?
1 □ Yes 2 □ No

4 Homicide

29a. Certifier

5 Pending investigation 1 Natural 2 Accident 6 □ Could not be 3 ☐ Suicide determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

title of certifier 29b. Signature and

29c. License number D2/930

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr ME TITIX MA

31. Date filed (Month, Day, Year) State Registrar

Medical

istrar's Signature

S GREEN ST BALTIMORE, MI) Z1201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

	-	For State Registrar		State of	t Mary		•	rtment of H tificate of L				Reg. No	/ 1 1 1 1	9	14/25
Physicia	an	1. Decedent's Nam	ne (First, Middle,	Last)							2. Date of De		ay 2009	əar	3. Time of Death
/Medic				nxner				4b, City, Town, or	Location	of Doath	April		, 2009 c. County of		1:40 P M
Examin	er	4a. Facility Name (Casey Ho		give street and nui	TIDer)			Rockvill		OI Douil		- 1	Montgo		У
Funeral		5. Social Security N		6. Sex	7. Age (In	yrs. last birth	day)	If Under 1 Year Months Days	If Under		8. Date of Bir (Month, Da	rth a <i>y, Y</i> ea <i>r</i>	-) 9		lace (State or Foreign
Director		209-24-7		1□ M 2XF		76_ ^{Yr}	rs.				May 3,	19:	32 P	enn:	sylvania
land ow		Usual Residence o	10b. County		10	c. City, Town o	or Loc	ation						1	0d. Inside City Limits
Mary a-fsh	ctor	MD	Montgo	mery	Ga	aithers	bw	rg							1 □Yes 2X No
ith the or 28	Director	10e. Street and Nu	ımber					10f. Zip Code					itizen of Wha	at Coun	try?
sath w	eral	436 Gira	rd Stre	et #302 12. Was Dece	odont Evor	rin II S	13 \	20877	isnanic O	rigin? (Spe	ecify Yes or No	USA	14. Race -	Americ	an Indian.
ter de	Funeral	11. Marital Status 1 □ Never Mari	ried 2□ Marrie	Armed Fo 1 ☐ Yes	rces? 2 X No	111 0.3.		Vas Decedent of H Yes, specify Cuba			Rican, etc.)		Black,		
2-UUSO 72 hours aff natural", or	ठ	3 XWidowed		If Yes, Gi Year or D	ve ates:		1	□Yes 2X No	Specify	y: 			Specify:	Whi	te
of Z 1 Z 15-UU30 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be muffied at	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk						st of worki	ng	16b.	Kind of Busir	ness/Ind	dustry			
within than than	dwc	Elementary/Sec	ondary (0-12)	College (1	I-4or 5+)			ng Clerk	"/			He	althca	re	
a filed al Hyg	BeC	17. Father's Name	(First, Middle, L	ast)							(First, Middle	e, Maide	en Surname)		
yiai ould bo Menta arked atic e	2	Irvine W	Viest	·········						ce Scl					
VICE Short I S		19a. Informant's N						g Address <i>(Street a</i> Palm Gra							
1 and 1 and Healt tem 2		20a. Method of Dis	_	epriew	- 2			sition (Name of natory or other place			Date		Location - Ci		
antimor rmit. Pages spartment of portant: If it y injury or or ce.		1 ☐ Burial 2 4 ☐ Donation	1 Burial 2 Decremation 3 Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory 04/18,								8/09	Od	Odenton, MD		
palitimore, Intervient 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madeal Event her must be notified at once.		21. Signature of F	uneral Service L	icensee H	/	MO1 251		ing Home							784 MD 21029
		23a. Part 1. Enter	the disease, or o	complications that conly one cause on e									QL12DV1		Approximate Interval Between
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uted d insit	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease of that initiated event	derlying or injury	Buc to	(0) 45 4 00	onio aquento a	,,								
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certifii certifii nding p	/Me	IF FEMALE:	-11	23c. If yes, ou	tcome of p	pregnancy							23d. Date	of deliv	very
requires that the death cert neen signed by the attending	Physician/M	23b. Was deceded in the past 12 1 Yes 2	2 months?	4 ☐ Preg	nant at tin	Fetal death ne of death		Ectopic pregnand Other (specify)	у				Mont	h	Day Year
at the lby the stache	hys	9 Unknow	rn	9 🗆 Unkı							220 Did	Itahaaa	o uso contrib	uto to t	the cause of death?
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v requ	etec										24a, Wa	san	24b. W	ere auto	opsy findings available
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ITal lan: T rtifical xtor, pe	l ou	25. Was case refe	erred to medical						26. Pla	ce of Deat	h (Check only		10	_,,03	
OT V Physic	To B	examiner? 1 ☐ Yes 2 ₹	X No			2 ER/Out	<u>' </u>		4 🗆	Nursing Ho	ome 5 Re				hospice
on C	ioi:	27. Manner of Dea	ath 5 ∐ Pending investig	,	of Injury oth, Day, Yo	(ear) 28b. Ti	ime of jury	Wor	ryat k?]Yes 2[□No	28d. Describe	e now in	ijury occurred	1	
DIVISION I or Attending after death. I Director: After d in by the fune	ficat	2 Accident	6 Could n	ot be 28e. Place	e of Injury	- At home, fari	m, str	eet, factory, office	1100 21		28f. Location	(Street	and Number	r or Rur	ral Route Number,
Calor safter	Certification:	4 🗆 Homicide	doto	bullo	ling, etc. (<i>Эреспу)</i>					City or To	OWII, SI			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)	1 X Certifyin 2☐ Medical I	g Physician: To th Examiner: On the and mai	e best of r basis of ex aner stated	xamination and	, deatl d/or in	h occurred at the to vestigation, in my	ime, date opinion, c	and place death occur	, and due to the rred at the time	ne cause e, date a	e(s) and mar and place, ar	ner as	stated. to the cause(s)
Fo the within Fo the	Me	29b. Signature an	nd title of certifier				211	29c. Licens	se numbe	er \ra			Date signed		
) Je	rekyn	e kou	CUL	104/	"	1000	63 7	148		Apr	il 17	, 20	JU9
1300		30. Name and add	e Kouato	who completed cau chou,M.D	. 600	1 Munca	ast	er Mill	Rd.	Rockv	ille,	MD 2	20855		
Sta Regist	ate rar	31. Date filed (Mo	APR 2	0 2009 32.	Registrar's	Signature .	4	backer							

DHMH 17 Rev 1/2001

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		State of Maryland / De	partment of Health and Mer	
		CA-A-	ertificate of Death	Reg. No. 2009 14 26
Physi	cian	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year 3. Time of Death
/Me	dical	Barbara A. Lemon 4a. Facility Name (If not institution, give street and number)		pril 14 2009 1:15 A M
Exam	iner	910 Marine Dr.	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
Funera	al	Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth 9. Birthplace (State or Foreign
Directo	or	212-42-8916 1 M 2 F 66 Yrs	Months Days Hours Min. A	pr 3 1943 N. Carolina
rland ow		Usual Residence of Decedent 10a. State	Location	10d. Inside City Limits
Mary a-f sh	ţ	Maryland Anne Arundel Annapo	olis	1 X Yes 2 □ No
ith the	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
s 23a	eral	910 Marine Dr.	21409	USA
fter de	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican) 	Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.
ours a	l p	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □Yes 2X No Specify:	Specify: Black
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hyglene, ed other than "natural", or items 23a or 28a-f show event, ine Medical Exercities and to a modified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Git	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/Industry Anne Arundel Co.
21215-0036 d within 72 hours aft glene, or than "natural", or the Medical Exami	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	lerk Typist	Library Headquarters
e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)
arylar should b and Ments s marked umatic e	10	Samuel Gilmer	Helen Qu	een
2 2 2 2				oute Number, City or Town, State, Zip Code)
re, N 1 and 1 Health tem 27 tem 27		Carmela Watts (Daughter) 42 20a. Method of Disposition 20b. Place of Dis	O Summer Wind Way sposition (Name of rematory or other place) Date	
Pages nent of int: If Its		TEMBURAL 2 LI Cremation 3 Li Removal from State 1	crest Cemetery 4/	17/09 Annapolis, Md.
Baltimore, permit, Pages 1 ar Department of Hea Important: If Item 3 any injury or other	9	21. Signature of Funeral Service Licensee	Mortuary, P.A.	
m #0.5 # :	51	Jarry A. Beese MOS 83	821 West St. Anna	
		23a. Part 1. Enter/fine disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1	spiratory arrest, Approximate Interval Between Onset and Death
Physiciai /Medica	_	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	lung cancer	How
Examine				
st st	ine.	Sequentially list conditions, it are the first terms that cause. Enter Underlying Cause (Disease or injury that initiated events		
60, be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
e ys	cal	d		
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE:		
. Box death cer e attendir d for use	ian/	In the past 12 moraris?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Ye ar
the d	hysic	1 Yes 2 Mo 9 Unknown	5 Li Ottiei (specify)	
cords, P.O. requires that the dependence of the signed by the should be detached	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Vital Records, sician: The law requires ti certificate has been signe rector, page 2 should be d	ted			Yes 2 No 3 Probably 4 Unknown
Rec e law has b	Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		25. Was case referred to medical	26. Place of Death (C	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other:	Residence 6 Other (Specify)
ISION Of Attending Physicator; After this control of the funeral directions of the funeral direc	l.:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injur	y Work?	Describe how injury occurred
Division of a or Attending Phy after death. I Director; After this d in by the funeral d	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 ☐Yes 2 ☐ No	Location (Street and Number or Rural Route Number,
Divi	Certification: T	4 Homicide determined building, etc. (Specify)	5.1001, 140107), 011100	City or Town, State)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
o the lithin 2 o the lomple 1	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
F S F S	+	Jeann wen	DS2830	April 14,2009
1 Rock	7	30. Name and address of person who completed cause of death (Item 23a) (Typ	pe, Print) O at the last Rexact to	29d. Date signed (Month, Day, Year) April 14, 2009 Amagails MO 21401
PA PA	tate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	JBISIGET IS	- Thomagasis in city
Regis		APR 16 2009 Suns S.	backer	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Ttem 17 per FH G891 5/27/09 dk

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1-05 AM 23 0 /Medical 4a. Facility Name (If not institution, give street and number)

St. Catherine's Nursing Home 4c. County of Death 4b. City, Town, or Location of Death Examiner Emmitsburg, rubif Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Dec. 26, 1 Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 189-09-6678 1 M 2 F 93 1915 Gettysburg, Director PAUsual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 □ No Director PA Adams Gettysburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31 E. Middle St. 17325 UŞA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 Lry or other traumatic event, the Medical Examiner musi Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Slentz Luther Lentz Jenny Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorene Carbaugh, Daughter 31 E. Middle St., <u>Gettysburg, PA 17325</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Cemetery 4-27-2009 Gettysburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.L. Davis Funeral Home Signate of Funeral Service 12525 Bradbury Ave., Smithsburg, MD 21783 u Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumani disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed as the burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ed by the a detached f I ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, PV 2 No 3 Probably 4 Donknown 1 ☐ Yes page 2 should Completed need 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has t autopsy performed certificate 1 Yes 2 No Physician: rector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 9 3□ DOA After this funeral dir To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple TAD MD 31. Date filed (Month, Day, Year) . Registrar's Signature State MAY - 1 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 5:00 P. 2009 Mandley April 17 Vincent Raymond 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3940 3rd Steet North Beach Calvert If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 01-28-1927 579-30-8497 82 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYYes 2 □ No North Beach Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3940 3rd Street 20714 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🙀 No Specify. 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) drywall mechanic unknown construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DePau1 Vincent Mandley Helen Dorothy Lunsford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes F. Mandley, spouse P.O. Box 394, North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens: 04-21-2009 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee William 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -20 NA STAGE disease or condition resulting in death) Due to (or as a consequence of) 1/ ART SCLEROTIC Threeta Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

20678

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

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Completed

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Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only one)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evernher must be notified at once.

Baltimore, Maryland 21215-0036

physician and the burial-transit attending pl for use as t ned by the a s been signed b should be deta certificate has b rector, page 2 sh funeral director, After this s after death.

I Director: At it in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 143000 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours a

To the Funeral I

completely filled

the Hospital

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filled

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 20 2009 Registrar DHMH 17 Rev 1/2001

Dave

KINCE

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14^{Day} Month 4 **Physician** 2005 10:35 AM Jeffrey Peter Marx /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ocean Pines Worcester 54 Boston Dr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. 1 XM 2□ F Months Days Hours 51 10/3/1957 220-56-5554 CA Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evaning must be notified at 1 ☐ Yes 2X No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 54 Boston Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Haring Henry P. Marx 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Cambridge Place, Ocean Pines, MD 21811 Mildred Marx / mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 4/18/2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garden of the Pines Ocean Pines, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EW MINNOTES HSPHYXIATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter the causa Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 signed by the a d be detached for 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? this certificate has al director, page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: PRINK TO M Division Hospital or Attending 5 ☐ Pending investigation 1 ☐ Natural HANGING 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
54 Bostone 32 GEAN PINES 3 Suicide determined 4 Homicide AT STONE To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BA5

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#8, 18, 19 operFH4/27/09, EMW, Noto Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 6, 2009 4:51P M McLamore Theodore 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month Day, Year) Aug. 8, 1927 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 81 152 M 2 □ F Carolina 249-34-5288 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No MD Prince Georges Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20745 5115 Woodland Blvd. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: Black 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlie McLamore 19a. Informant's Name/Relationship (Type. Print) Daughter Edith McLamore-Shelton/ Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Harmony Memorial 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/09 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Linsee 22. Name and Address of Facility Andre Sanders & Sons Mortuary P.O.Box 25124 Alexandria, VA or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Asystole/Cardic Arrest Due to (or as a consequence of) (L) Heel Ulcer/Infected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Osteomyelitis Due to (or as a consequence of) Failure To Thrive/Sin Peg Tube Feeding

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evertiner must be notified at once.

Baltimore, Maryland 21215-0036

and physician attending properties for use as After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine by Physician/Medical Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3 Ectopic		2	3d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resultin	ng in the underlying	cause given in Part I.		se contribute to the cause of death?] No 3 ☐ Probably 4 ☐ Unknown
	· · · · · ·			24a. Was an autopsy performed? 1 □Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER	l/Outpatient 3 ☐ □	OCA Other: 4 Nursing	Home 5 ☐ Residence 6	☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Bb. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	roccurred
3 Suicide 6 Could not by determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,

29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Nathasha Haag, MD 31. Date filed (Month, Day, Year)

17

20814 8600 Old Georgetown Rd. Bethesda, MD

State Registrar

Medical

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otato of marytane	Ceri	ificate of	Death	F	Reg. No.	000		
	Physici	an	1. Decedent's Name (First, Middle, Last)	C MACON				2. Date of Dea Month	Day	Year	3. Time of Death	
4	/Medi	cal 🐰		G. MASON	<u>-</u>	4h City Town o	r Location of Deatl		4, 200	ity of Death	6:30 A ^M	
	Examir	ier	4a. Facility Name (If not institution, give st 915 FLIZABETH STF				E DE GRA			HARFOF	SD	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h /, Year)	9. Birthpl Count	lace (State or Foreign	
dar.	P P		Usual Residence of Decedent	10c City	Town or Loc	ation				1	0d. Inside City Limits	
	e Marylar Ba-f show tiffed at	Director		RFORD	, TOWITOI LOC	F	HAVRE DE				1 XYes 2 □ No	
	23a or 2 ust be no		10e. Street and Number 915 ELIZABI			10f. Zip Code	21078		UNIT		Vhat Country? TED STATES	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1	1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No	lispanic Origin? (S an, Mexican, Puer Specify:	pecity Yes or No- to Rican, etc.)	Rican, etc.) 14. Had Black Specif		ce - American Indian, ick, White, etc.	
2	72 ho natur ii:al	sted	15. Decedent's Educ (Specify only highest grade	ation ((Give k	ent's Usual Occup	during most of wo	rking	16b. Kind of	Business/Ind	dustry	
2	d within 72 ho giene. r than "natu the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired VAREHOUSE	d) -		וואדיים	יוט כתייטי	TES ARMY	
2	filed w Hygier ther then		12 17. Father's Name (First, Middle, Last)		V	VAREJOUSI		ne (First Middle	First, Middle, Maiden Surname)			
Maryland	be do do	To Be	ROBERT THOMAS MASOI	N			BRENDA F					
	s 1 and 2 should f Health and Mer fem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type DENEEN C. MASON / S	SPOUSE	915 EI	LIZABETH	STREET,	HAVRE DI	E GRACE	YLAND 21078		
Baltimore,	0 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emovai irom State - i		ition (Name of latory or other place FOREST VI		^{Date} 23/09		n - City or To NGS MII	own, State	
Balti	permit. Pag Department Important: I any Injury conce.		21. Signature of Funeral Service License	e - Coli	22.	Name and Addre	SS of Facility O'T' FUNER	RAL HOME,	P.A.	ACE. M	ARYLAND 21(
,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. On hosis Due to (or as a consequence)	ng, such as cardia	c or respiratory a	rrest,	2	Approximate Interval Between Onset and Death yews mwsh			
68760,	rificate be executed ng physician and as the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to hamedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):		4-25					
.O. Box	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у			Date of delive	ery Day Year	
<u>α</u>	tuires that signed b	by	Part II. Other significant conditions con Hepahh's CVII	tributing to death but not resu		derlying cause giv	ven in Part I.	23e. Did t			he cause of death? cably 4 ∐Unknown	
or Vital Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed	Acquired inm	modeficie	nay s	yndro	re	24a. Was auto perfo 1 Yes		b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of	
/ita	Physician: The rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?	9-1.		Lou		ath (Check only o	one)			
7	di Si	L 2	I T AGS ET NO		ER/Outpatien	OLI DOA	ner: 4 🗆 Nursing		dence 6 🗆 0		fy)	
	ifter Ing	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ryaτ rk?]Yes 2∐No	28d. Describe	now injury occ	currea		
Division	or Attending fter death. Director: Afte in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, stre		Tes Z No	28f. Location (City or To	Street and Nu wn, State)	mber or Rum	al Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier Check only one) 2 Medical Examin	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause							stated. to the cause(s)	
	o the ithin i	Mec	29b. Signature and Hill of certifier	and manner stated.		29c. Licens	se number Mi	5	29d. Date sig	ned (Month,	Day, Year)	
	F≯Fŏ		In Claw	UND.			5050	1	04/	14/	2009	
, :	34/VA		30. Name and address of person who co				ITAZ	BALTIN	ORE	MD		
-	St	ate	31. Date filed (Month, Day, Year) APR 17	32. Regisfrar's Signa					<u> </u>	1000		
	Regist	rar	APR 1	LUUJ Keneva	10. 1	4 aura						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15, 2009 April 11:23A M June Melone Michael /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carrol1 Carroll Hospice Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Months Hours Days 69 1 ☐ M 2 XX Oct. 1939 Virginia 230-48-7443 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be realfiled at 28a-f shov 1 Yes 2 No Directo Walkersville Marvland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21793 United States 50 Hampton Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 🔯 No 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White þ If Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home if Health and Mental Hygirltem 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Buford George Daniel John Irvin Melone, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond F. Michael/Husband 50 Hampton Pl. Walkersville, MD 21793 20b. Place of Disposition (Name of cereiers cemators gother place)
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition April 18. permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Offer (Specify) Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of F MI Service License 9501 Catoctin Mtn. Hwy. Frederick. MD 21701 23a. Pager. Enter the disease, or con shock, or heart failure. List on Immediate Cause (Final cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. Examiner signed by the attending physician and be detached for use as the burial-transit by Physician/Medical Be Completed

Physician /Medical Examiner

within 72 hours after death with

Baltimore, Maryland 21215-0036

icate has been significate has been significated by page 2 should b certificate Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:

completely filled in by the 1

12 State

disease or condition	End Stage Kluney Fallure		6 years
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, light, and to immediate cause. Enter Underlying Cause (Disease or injury	b]
that initiated events resulting in death) Last	c		
	.d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 ☐ Ctopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Dialysis Relat	ed Amyloidosis	1 ☐ Yes 2 🔀 No 3 🗆 I	Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 Yes 2 2 No 1 Yes	
25. Was case referred to medical examiner?		ath (Check only one)	Hognice
1 ☐ Yes 2 🔀 No		Home 5 ☐ Residence 6 🗷 Other (Sp	ecity House
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
29a. Certifier (Check only one) 1X Certifying Phase Check only 2 Medical Example 1	nysician: To the best of my knowledge, death occurred at the time, date and plac ininer: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	e, and due to the cause(s) and manner urred at the time, date and place, and di	as stated. ue to the cause(s)

29c. License number

D0060764

29d. Date signed (Month, Day, Year)

2009

21701

31. Date filed (Month, Day, Year) APR 17 Registrar

29b. Signature and title of certifie

Medical

Branislav S. Romanic, M.D. 32 Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 Toll Hose Ave. Ste. H-4 Frederick, arke

09-02984

Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

226	I voe or Print in Die	ack indentitie into En		
usc	, ypo or		L and Montal Hyaic	ne
	State of Mandand	Department of Health	n and Mental Hygic	2110

	De	For State	Certii	icate of Death	Reg. No	3. Time of Death
Physicia	n/ 1.	Decedent's Name (First, Middle,Last)			Month Day April 14, 2009	Year 1437 hrs
ical Examin	er	Amy Garnette a. Facility Name (if not institution, give	Merricks	4b. City, Town, or Location of	of Death	c. County of Death
	4	a. Facility Name (if not institution, give 8113 McDonough Road	street and number /	Pikesville		Baltimore County
	_	Social Security Number 6. Sex	7. Age (In yrs. last	Diffiday)		M/DD/YYYY) 9. Birthplace (State or Foreign Country)
Funeral Director		214-02-6176 1	M 2XF 32	Yrs. Months Days Hours	March 19	, 1977 _{Pennsylvania}
	_	sual Residence of Decedent Oa. State 10b. County	10c. City, To	own or Location		10d. Inside City Limits
w any	1.			Owings Mills		1 Yes 2 X No
/land -f sho	힐	Maryland Baltimo Oe. Street and Number		10f. Zip Code		Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	9518 Georgian	Way	21117		United States
th the 23a o notifi		Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ori	gin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
ath wi	Funeral	1 XNever Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexicar	i, Puerto Ricari, etc.)	White
er de	리	3 Widowed 4 Divorced	If Yes, Give Year	1 Yes 2X No specify		Specify:
irs aft tural'	화	15. Decedent's Education (Specify or	ny mgmaat grant and a	16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		b. Kind of Business/Industry
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thin 7 re. than tedice	du		5+	Student	er's Name (First, Middle, Maid	
5-0 ed wi tygie other	S	17. Father's Name (First, Middle, Last			na Holscher	
be fill purked vent,	Be B	David Merricl	CS	19b. Mailing Address (Street and Nu	Imber or Rural Route Numbe	r, City or Town, State, Zip Code)
hould hould a ma ma maric em	입	19a. Informant's Name/Relationship (10984 Rocky Ridge	Rd. Keymar	, MD 21757
MC 2 s alth as m 27 aum:	-	David Merricks /	1.20h P	lace of Disposition (Name of cemetery,	Date 2	0c. Location - City or Town, State
S La of He of He If ite		1 Burial 2 X Cremation 3		rematory or other place)	4/18/2009	Frederick, Marylan
Page ment tant:		4 Donation 5 Other Specify		uffer Crematory	Stauffer	Funeral Home
Salt ermit eparti mpor ijury	(2)	21. Sign if ye of Funeral Service Lice	V 41	1621 Opossumt	own Pike. Fr	ederick, MD 21702
		224 Part I Enter the disease or com	plications that caused the death.	Do not enter the mode of dying, such as	cardiac or respiratory arrest	, shock, or heart Approximate Interva Between Onset and
Physician 'Medical			ach line. V Multiple Blunt Force Inju	irios		Death
aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of			
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ox 6 The cell of	sici	1 Yes 2 No 9 ✔ Unkno	Pregnant at time of de	other (Specify)		
n of Vital Records, P.O. Box 6876(ding Physician: The law requires that the death certificate h. After this certificate has been signed by the attending phys fineral director name 2 should be detached for use as the b	Physician/M		O O I I I I I I I I I I I I I I I I I I	resulting in the underlying cause given in		pacco use contribute to the cause of death?
ires that the signed by the detached	à	Part III Other Significant Services	•		1 Yes	2 No 3 Probably 4 Unknown
S, F quires en sig	Te l				24a. Was a autops	
cords, law requir has been s	e				perform	med? death?
Division of Vital Records, tal or Attending Physician: The law requirents after death. By Director: After this certificate has been is the fineral or nage 2 should it in her the fineral director, nage 2 should it.	Completed			26 Place of De	eath (Check only one)	
Vital Recysician: The Ihis certificate I	a a	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other		Residence 6 Other: Scene
Vit hysic this	2	1 ✓ Yes 2 No	1 Inpatient 2 28a. Date of Injury	28b. Time of Injury 28c. Injury at V	Verk2 28d Describe t	now injury occurred
of Ning Physics		27. Manner of Death 1 Natural 5 Pendin	(Month, Day Year)	0000 hrs 1 Yes 2	IDriver auto s	sport utility vehicle collision
ttend death ctor:	ertification:	2 Accident Investig		home, farm, street, factory, office buildin	g, etc. 28f. Location (S	Street and Number or Rural Route Number, C
Divisior pital or Attend ours after death leral Director:		3 Suicide 6 Could r	not be		or Town, S 8113 McDono	tate) ugh Road, Pikesville , MD
Divi	= 1 C				nd place, and due to the caus	e(s) and manner as stated.
n 24 h	completely	(Check only one) 2 Medical Exam	ner: On the basis of examination	adge, death occurred at the time, date an and/or investigation, in my opinion, dea	th occurred at the time, date	and place, and due to the cause(s)
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	Madical	29b. Signature and title of certifier	and manner stated.	29c. License nur		29d. Date signed (Month, Day, Year)
	2	Zab. Signature and title of certifier	.1	O.C.M.E		April 15, 2009
		peuce	-) N'			
		30. Name and address of person w	ho completed cause of death (Ite	em 23a) aminer 111 Penn Street, Bal	Itimore MD 21201	
4			Assistant Medical Exa	aminer 111 Penn Street, Dai	Illinoie, MD 21201	
4		Russell Alexander MD.	Assistant Medical Exa	20110		
	Stat	Russell Alexander MD. 31. Date filed (Month, Day, Year)	Assistant Medical Exa			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03164 State of Maryland / Department of Health and Mental Hygiene John McCambridge Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1540 hrs April 20, 2009 Medical Examiner John McCambridge, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Indian Head 5 Davis Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1947 New Jersev June 27. 61 Director 149-38-6314 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 X Yes 2 No 23a or 28a-f show notified at once. Indian Head Charles Maryland after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20640 5 Davis Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces? Never Married 2 X Married №1968 1 X Yes Specify: White Ē Yes 2 X No specify: f Yes, Give Year 4 Divorced 3 Widowed 1976 Examine 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Medical is marked other than U.S. Government Safety Occupation Health Special 4 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Runion John McCambridge æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 5 Davis Drive, Indian Head, Md. 20640 Deborah L. McCambridge tant: If item 27 is Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition oril 25, 20b9 Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Funeral Alexandria, Virginia Service ment c Donation 5 Other Specify ²² Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, 21. Signature of Funeral Service M00668 Md. 20640 Approximate Interval t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart disease, or complication Part I. Inter the disease, or complications that caused the decade of the failure. See any one cause on each line.

Atheroslcoeritc cardiovascular disease Between Onset and Physician Death /Medical Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed #1 as noted, 23a,27,perME, g891 5/15/09 TT Physician/Medical X UNPENDED **AMENDED** attending physician for use as the burial -23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown 2 Completed 24b. Were autopsy findings available 24a, Was an After this certificate has been s funeral director, page 2 should prior to completion of cause of autopsy death? performed? 2 Νo ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 V Other: Scene DOA ER/Outpatient 3 Inpatient 1 🗸 Yes 28d Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 X Natura Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 3 Could not be Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Che one) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 21, 2009 O.C.M.E. au 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed (Mont) State arks known Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** APR 2009 BENITO MACARANAS 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner BETHESDA** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth (Month, Day, April 3, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Philippines Months Days Hours **X** M 2 □ F 85 586-60-0479 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating the profiled at 1 Yes 2XXNo Director Oxon Hill Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20745 1210 Lindsay Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. txxYes 2 No. If Yes, Give Vietnam Year or Dates: 1 ☐ Never Married 2 ☐ Married Filipino Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4or 5+) Elementary/Secondary (0-12) Military U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felisa Manangan Cruz Catalino ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1210 Lindsay Road Oxon Hill, Maryland 20745 Grace Macaranas / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/24/2009 Cheltenham, Maryland Maryland Vet. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signat of Funda Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland Pirt . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spoks, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm die te Cause (Final disea e or condition **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has the raid director, page 2 s autopsy performed? 2 No 1 □Yes 2 No Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fil

IVA

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LCDR MC

29b. Signature and title of certifier

MICHAEL BAYDARIAN

01055104A (IN) NATIONAL NAVAL MEDICAL CENTER

29d. Date signed (Month, Day, Year)

BETHESDA MD 20889-5600

29c. License number

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g891 5-5-09 yt State of Maryland / Department of Health and Mental Hygiene pgcbj 1-State Registrar Amend#20bpercem4/28/09 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL **Physician** 2009 12:30 A M MORGAN RONNIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FORESTVILLE HEALTH & REHAB FORESTVILLE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 578-70-5124 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 XM 2 □ F Director 56 JAN 11 1953 WASHINGTON, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ira Medical Examinar Inast Darrottined at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director MDPRINCE GEORGE'S SUITLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3600 MAYWOOD LANE # 105 20746 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE CLERK PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEWIS E. MORGAN ဥ HARRIET HART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAMILLE E. MORGAN/WIFE 3600 MAYWOOD LANE # 105 SUITLAND, MARYLAND permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. 20746 20b. Place of Disposition (Name of Resurrection Kesurrection KARMONY CEMETERY 20c. Location - City or Town, State Clinton Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cem 4/22/2009 22/2009 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician REPATIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ALCHOLIC burial-trar Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical HEPATITIS C 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the ue within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? 1 ☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? $_{\mathbf{V}}$ Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 □Natural 2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🄼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 4-15-09 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 OLD BRANCH AVENUE SUITE 409 CLINTON, MARYLAND 20735 BAHRAM PISHDAD M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 7 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Dav **Physician** Jobert D. MC Neis 2009 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Annapolis Center 6. Şex 1 M M 2 □ F 3. Date of Birth (Month Day, Year) 9-11-1963 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 45 Months Days Delaware 222-46-6530 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Actical Examinar in ust be notfled at 1 □Yes 2K No Queen Anne's Stevensville Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21666 USA 801 Kimberly Way Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 M Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Ş Q 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Menial Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Inc. Ma. Once. College (1-4or 5+) Elementary/Secondary (0-12) Counseling Addiction specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacqueline Hackett Robert A. McNeil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 801 Kimberly Way Stevensville, MD 21666 Erica McNeil 20b. Place of Disposition (Name of cemeter, crematory or other place)
Summit Cremation
Services, LLC 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Kremation 3 🗷 Removal from State Cremation 4/24/2009 Camden-Wyoming, DE es, LLC 4/24/2009 Camden-Wyoming, DE 22. Name and Address of Facility Pippin Funeral Home, Inc. 119 W. Camden-Wyoming Ave., Wyoming, DE 19934 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final My6 Car **Physician** disease or condition resulting in death) /Medical Due to (or each consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: Hospital or Attending Physician; The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

State Registrar

Medical

29a. Certifier

29b. Signature

(Check only one)

R. Jeffrey

31. Date filed (Month

and title of certifier

DHMH 17 Rev 1/2001

within 2 the

and manner stated.

844

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schnidlein

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Richie HWY. Juine 206 SevernA PARK, MD 21146

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day PAUL \mathbf{A}_{M} MUMFORD, SR. 19, 2009 APR. 11:24 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN, MARYLAND WORCESTER COUNTY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 X M 2 □ F Months Hours 74 214-32-5887 AUG 26, 1934 WHALEYVILLE MD Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location MARYLAND BERLIN WORCESTER COUNTY 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10124 PIN OAK DRIVE 21811 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1961-63 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. Specify: BLACK 3 Widowed 4 N Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AGRICULTURAL Elementary/Secondary (0-12) College (1-4or 5+) NURSERYMAN 8TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN MUMFORD NANCY PITTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA MUMFORD 523 FLOWER ST. BERLIN, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date XX Burial 2 Cremation MD VETERAN'S CEM. APR 27,2009 HURLOCK, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility WATSON FUNERAL HOME P.O. BOX 125 MILLSBORO, DE MO 1361 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one or use on each line. Immediate Cause (Final ORONARY disease or condition resulting in death) Due to (or as a consequence of): ONGES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**2** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

certificate be executed P.0. Records, Vital or Attending Physician; ot Zyd -- Division

State

Physician

/Medical

Examiner

Director

Funeral

Completed

Funeral

Director

Show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the "Medical Examiliar must be notified at

Maryland 21215-00

DO D y Baltimore, I

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Pages 1

Physician

/Medical

Examiner

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certificate

within 24 hours after death

To the Funeral Director:
completely filled in by the

Examine

Physician/Medical

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Completed

Be

Certification: To

Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifie

completed cause of death (Item 23a) (Type, Print)

and manner stated.

corhaes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

400 Eastern Shore Drive Satisfury MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar 1. Decedent's Name (First, Mic	Idle, Last)			unca	te of Dear	LI I	2. Date of De		2009	3. Time of Death
Physiciar /Medica Examine		Doris Nicinski								Day 14	Year 200 9	5:23 a ^N
		4a. Facility Name (If not institut	ion, give street and nur	mber)		4b. City	Town, or Location	on of Death		4c. C	ounty of Dea	th
		Holy Cros	s Hospital				Silver					gomery
Funeral Director		5. Social Security Number 216-34-0049	6. Sex 1 □ M 2 bx F	7. Age (In yrs. 85	last birthday) Yrs.	If Unde Months		der 24 Hrs. rs Min.	8. Date of Bir (Month, D. November			thplace (State or Foreigountry) Poland
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-f sh	ţoţ	Maryland Mo	ntgomery				Silver	Spring				1 ☐Yes 2 😿 N
r 28a	Director	10e. Street and Number	педошегу			10f. Zi	p Code	op. 16		10g. Citize	en of What Co	ountry?
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if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece Armed Fo		.S. 13.	Was Dece If Yes, spe	dent of Hispanic ecify Cuban, Mex	Origin? (Sp tican, Puerto	ecify Yes or No Rican, etc.)	D- 14	I. Race - Ame Black, Whit	
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other vent, I	Be C	17. Father's Name (First, Midd.	e, Last)				other's Name	e (First, Middle				
Mental arked o	2	David	Enoch					P	Roza (Unknown)			
land Mer Is marke aumatic		19a. Informant's Name/Relatio	nship (Type. Print)		19b. Mailir	ng Addres	s (Street and Nu	ımber or Rur	ral Route Numb	er, City or	Town, State,	Zip Code)
Health tem 27 I		Felix Nicinski	- Husband	1			alton Ter					
		20a. Method of Disposition 1 Burial 2 □ Crematio 4 □ Donation 5 □ Other		State	Place of Dispo cemetery, crer ean Memo	natory or	other place)	1	7/2009		etion - City or	
Department of Important: If it any injury or once.		21. Signature of Fundral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc.						S. P. Harrison	311			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between		
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Medical		resulting in death)	u.	(or as a conseq		2011						
aminer	Ļ	Sequentially list conditions,	y list conditions, b. Upper Gastrointestinal Bleed									4 hours
sit	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	diate									
physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
	edical		d									
attending for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna		□Ectopic	pregnancy			23	3d. Date of de	elivery Day Year
the at	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregi 9 ☐ Unkn	nant at time of o	at time of death 5 ☐ Other (specify)			World Day		Day Tour		
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been sign should be	ed by								1 🗆	Yes 2	No 3□ F	Probably 4 🗌 Unkno
has be	Completed								24a. Was			utopsy findings availal
ate	mo;							autopsy prior to completion of ca performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No			_	
certificate rector, page	Be (25. Was case referred to medi examiner?					26. P	lace of Deat	th (Check only	one)		
	2	1 Yes 2 No		Inpatient 2 🔼	ER/Outpatie	nt 3 □ □	OA Other: 4 [☐ Nursing Ho	ome_5 ☐ Res			ecify)
ig ig	ë	27. Manner of Death 1 ▼ Natural 5 □ Pen	28a. Date ding (Mon	of Injury th, Day, Year)	28b. Time o Injury		28c. Injury at Work?	_	28d. Describe	how injury	occurred	
= =	ati	2 ☐ Accident inve 3 ☐ Suicide 6 ☐ Cou	stigation Id not be 28e. Place	of Injury - At h	ome, farm, str	eet, facto	1 □ Yes 2 y, office	2 No	28f. Location City or To	(Street and	Number or F	Rural Route Number,
ath. r: After th ne funeral	iific	4 ☐ Homicide determined building, etc. (Specify)					d - 1 H - 1 d d - 1		City or Town, State)			
ath. rr: After th ne funeral	Certification:	000 00000000000000000000000000000000000										
ath. •r: After th ne funeral		29a. Certifier 1 🔀 Certification (Check only 2 Medicone)	al Examiner: On the b	e best of my kno basis of examina oner stated.	ation and/or in	vestigatio	n, in my opinion,	, death occu	rred at the time	e, date and	place, and du	e to the cause(s)
ath. ir: After	Medical Certifica	(Check only 2 Medic	al Examiner: On the b	asis of examina	ation and/or in	vestigatio	n, in my opinion,		rred at the time			ne to the cause(s)
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within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medic	id Examiner: On the band man	easis of examinationer stated. MD see of death (Iter	ation and/or ir m 23a) (Type,	29 Print)	n, in my opinion, Oc. License numb	ber 18	40	29d. Date		e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 13,2009 0949 Portillo April De Jesus /Medical 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Suburban Hospital 9. Birthplace (State or Foreign Figure 2) 980 Efounts alvador 8. Date of Birth (Month, Day, Ye) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 T F 29 none Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Evan item must be notified at 1 □Yes 2 XNo Germantown MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number El Salvador 20876 Amber Ridge Circle 12129 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Specify: White Completed by 3 Widowed 4 Divorced ed other than "natural", event, the Wedical Eve El Salvadoren 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Portillo Cabrera Sabino ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2e0 8 7 6 19a. Informant's Name/Relationship (Type. Prily)rother 12129 Amber Ridge Circle Germantown, Md. Moises A. Portillo Cabrera/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot San Miquel, 1X Burial 2 Cremation 3 XR9 noval from State Municipal Cemetery 4/20/2009 4 ☐ Donation 5 ☐ Other (Specify) El Salvador uneral Service li en ee PHILIPADES RINALDI FUNERAL SERVICE, P.A 21. Signatur 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such at cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Immediate Cause (Final めいへ Physician 20 /Medical resulting in death) we to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last (or as a consequence of): Examine law requires that the death certificate be executed aftending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) QYes 2□No the detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø m nown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe has 2 No 2 No 1 ☐Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗌 No မ 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pl Within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Certification: After (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) 5

30. Name and address of person who completed cause of death

29b. Signature and title of certifier

(Check only



(Item 23a) (Type, Print)

and manner stated.

29c. License number

29d, Pate signed (Month, Day, Year)

		•	1 - State Registrar	State of Maryland		tificate of		_	Reg. No. 2	009	14141		
П	Physici	an	1. Decedent's Name (First, Middle, Las	ne Diane Pringl	2. Dat Mo				ath 14, 200	Year	3. Time of Death		
	/Medio		4a. Facility Name (If not institution, give	re-Jer		r Location of Death		1	nty of Death	6:30 A. M			
,.	LAGIIII		6307 Buckler Road			Clint				nce Ge	•		
	Funeral Director		5. Social Security Number 6. Se 578-68-6633 1. Usual Residence of Decedent	7. Age (In yrs. Ia ☐ M 2 X F 58	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 1	th ay, Year) 6,1950	9. Birthp Coun Sout	lace (State or Foreign try) h Carolina		
	yland now		10a. State 10b. County	10c. City,	Town or Loc	ation				10	Od. Inside City Limits		
	a-f st	ctor	District of Colu	nbia	Washir	ngton					1 X Yes 2 ☐ No		
	with th	Funeral Director	10e. Street and Number			10f. Zip Code	_		10g. Citizen o				
	ns 23	neral	2820 Erie Street	12. Was Decedent Ever in U.S		20020 as Decedent of H	lispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No		ed Sta ace - Americ	an Indian,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evan hard, and be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba □Yes 2 X No	an, Mexican, Puerto	o Hican, etc.)		lack, White, e			
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nd	e filed al Hyg I other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle					
ylaı	ould b	2	Joseph Pring				Joseph		enjamin				
Mar	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (7) Donnell Lee Pring		1	,	and Number or Ru Road; Cli				·		
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Ë	Page ment ant: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemovai from State	itage :	Memorial	Cemeter	7	Waldor				
Ball	Departiment mport		21. gnature Funeral Service Licens	201 E							orticians,		
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Division of Vital Records,	or Attendafter death Director: in by the	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ņe, farm, stre		163 2 110	28f. Location	Street and Nui	mber or Rura	il Route Number,		
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	Voit To t	Σ	29b. Signature and title of certifier	100		29c. Licens			29d. Date sig				
			20. Name and address of news		22a) /Time 5		8561		April	1/,	2009		
_	Ro		David J. Perry, M.		,		uite C-21	.51:Wash	ington	, D.C.	20010		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure			jcol	655-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:05 p 04 10 2009 Ethel Parker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year Days Months 1 □ M 2 ₺ F 578 40 2317 86 DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intit If iten 27 Is marked other than "natural", or items 23a or 28a-f show my or other trannatic event, II ** If Incles I ** simple must be notified at my or other trannatic event, II ** If Incles I ** simple must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County DC Washington XXYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3810 Carpenter St SE 20020 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo Specify: BLACK þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 yr College (1-4or 5+) 4vrs Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Edward SKINKER HATTIE WASHINGTON ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gail Williams- Daughter 1001 Taylor St NE Washington, DC 20017 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 04-21-2009 WASHINGTON, DC MT.OLIVET A2. Name and Address of FacilityJohn T RHines Funeral Home LLC 21. Signature of Funeral Service Liminsee 3005 12th St NE Washington, DC 20017 Juan Smit! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SENSIS YSTEMIC /Medical Due to (or as a consequence of) Examiner APPIRATION BILATERA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) been signed by the servould be detached ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performe certificate 1 ☐Yes 2 💢 No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-17874 4-13-09 N.S. NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

APR 1 7 2009

S. M. NAYAR, MD

Leve A. falle

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State of Registrar	Maryland / De <i>C</i>	partment of Hertificate of			ene ₂ 009	14143	
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		- ≯ - ō	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALDO IACONO, NO 501 S. UNION AVE HAVE de GRACE, MD 21078							9	
		1		30. Name and address of person who completed cause	of death (Item 23a) (Tv	pe. Print)	/	// /	10-1	(
		Q		ALDO IACONO ND 501	S. UNION A	Ve HAURO	de GRACI	e. Mo	21078	*	
		Sta	ate	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	- 1.01110	,,				
		Regist	rar	APR 2 1 2009 /2 week	. A. Day	le de la company					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04^{M9nth}3/2009 Physician 2005р м Albert Reed Samuel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George Hospital Prince George Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 04/25/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Screigh Country) **Funeral** Months Min. 1 🔀 M 2 🗆 F Days Hours 577-32-6687 79 Calhoun Falls Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is flection Event at most ten citilised at 10a. State 10b. County MD Prince George Riverdale 1 ☐Yes ZENO Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5323 Wiley St 20737 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$ TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 s Black 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Carrie Murray Elijah Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 5323 Wiley St Riverdale Md 20737 Ann Reed (Spouse) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition XIXBurial 2 Cremation 3 Removal from State Fort Lincoln cem 4/23/2009 Brentwood Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faciliting Roger Mason Funeral Svc 21. Signature of Ferneral Service of Ice 5801 Cleveland Ave Riverdale Md Approximate Interval Between Onset and Death 23a. Part 1. Enter or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne dis shock, or peart fa Immediate Carse (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of) **Examiner** Bladder Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Colon Carcinoma Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. After this certificate has been signed by the ifuneral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably À Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□No 1 □ Yes 1 ☐ Yes 2**/2/x**/o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending P after death. 1 X Natural 5 Pending investigation 1 □Yes 2 □No neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD 18784 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Oskeui MD

...

Registrar's Signature

ORIGINAL

3301 New Mexico Ave NW Wash DC Suite #31620016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April **Physician** 11:15 A M 12 2009 Gerald Spiess Donald /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert 8421 Sailboat Lane Lusby 8. Date of Birth (Month, Day, Year) 11/4/1934 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Louisiana 5. Social Security Numbe 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 □ F Months 74 Director 436-48-1974 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the "Marical Expression that the month once. 1 ☐Yes 2 ☑ No Director Calvert Lusby Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code United States 20557 8421 Sailboat Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □ No Speciahite \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) carpenter/AC/Refrigeration 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Gecondary (0-12) College (1-4or 5+) Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Merlin Spiess Stella Recknagle ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Sailboat Lane Lusby MD 20657 Claudia Ann Spiess- wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 14 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Alexandria Virginia Metropolitan Funeral Service 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Rome 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SA **Physician** disease or condition resulting in death) BUC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 si autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 12 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ca 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 1/2001

State

lew 6

30. Name and a

12070 Old Line Suite 207 Waldorf Maryland

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wisotsky Year) 09-03024

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aret Saylor		State of Maryland / Department 1- For State	ent of Health and Mental Hy ate of Death	giene Reg. No	2009 161				
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death				
ical Exami	iner	Margaret Saylor		Month Day April 15, 2009	1210 hrs				
		Facility Name (if not institution, give street and number) Northwest Regional Hospital	4b. City, Town, or Location of Death Randalistown	4	Baltimore County				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 414-34-6989 1 M 2 X F 81	hday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MN April 26	W/DD/YYYY) 9. Birthplace (State or Forei Country) VA				
		Usual Residence of Decedent			I 40 d Invited City Limit				
Maryland 28a-f show any d at once.	ř	MD Carroll Sykesvi			10d. Inside City Limit				
th the Maryland 23a or 28a-f sho totified at once.	Director	10e. Street and Number 262 Klee Mill Road	10f. Zip Code 21784	10g. C	itizen of What Country? USA				
and 2 should be filed within 72 hours after death with the Maryland teath and Manhal Hygend and Manhall "year or 12 and 23 or 28a-f She teath or 7 is marked other than "natural", or items 23a or 28a-f She traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I		14. Race - American Indian, Black, White, etc.				
after call, on	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		_{Specify:} white				
hours natur Cxami	ed k	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retire		. Kind of Business/Industry				
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ed wit lygien other the Me	Con	17. Tattlet 3 Name (1 113t, Wildele, East)		(First, Middle, Maide	en Surname)				
uld be filed wii Mental Hygien marked other c event, the M	Be	Joe C. Ringley		. Collin					
Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natur or other traumatic event, the Medical Exam	τ	Judy Creech (daughter) 62	b. Mailing Address (Street and Number or R 210 Margin Ave., Syk	esville, 1	MD 21784				
S I		cremate	of Disposition (Name of cemetery, tory or other place) View Memorial 4-2		c. Location - City or Town, State Sykesville, MD				
Pagiment		4 Donation 5 Other Specify:							
permit. Page Department of Important: injury or other		21. Signature of Funeral Service Licensee Page Harabet Stevent	22. Name and Address of Facility Ha: P.O. Box 195 Sykes						
nysician		23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.							
Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Blunt Force Injuries Due to (or as a consequence of):			Death				
	Examiner	Sequentially list conditions.							
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of): d.							
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law requires that has been signed b 2 should be deta	Completed			24a. Was an autopsy performed	24b. Were autopsy findings availal prior to completion of cause of death?				
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ysician: The this certificate director, page	Be (25. Was case referred to medical examiner? Hospital: 4 Inserticat 3 EP/O	26.Place of Death (Check						
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tending Phyleath. tor: After the funeral	ation:	(Month Day Year)	00 hrs 1 Yes 2 ✓ No	Driver auto aut	o collision				
spital or At nours after d neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / H	farm, street, factory, office building, etc. lighway	or Town, State	et and Number or Rural Route Number, C e) ite 26 at Johnsville Road , Sykesville				
the Ho hin 24 h the Fu	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	eath occurred at the time, date and place, and investigation, in my opinion, death occurred a	I due to the cause(s)) and manner as stated. place, and due to the cause(s)				
	₹	29b. Signature and title of certifier	29c. License number		ed. Date signed (Month, Day, Year)				
WJL 6		30/Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Α	pril 16, 2009				
		Russell Alexander MD. Assistant Medical Examiner		D 21201					
- S Regi	State		backer	OCME					
1 17 Rev 1/		2000	RIGINAL						
INEV 1/	2001	Or	NUMBE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6:09 PM SANDERS 04 2007 MARGARET Isabel 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON HOSPITAL EASTON TALBOT 7. Age (In yrs. last birthday)

91 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 12, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 😾 F 1917 214-42-9695 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show if than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 ☐ No Director Preston MD Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21655 United States 2662 Choptank Main Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White à 3 k Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Own Home Homemaker (Grad. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H permit. Pages 1 and 2 should be Department of Heath and Mental Important; If item 27 is marked of any Injury or other traumatic ever Roland Franklin Chambers Mabel Estella Chambers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James W. Sanders, Jr./Son 3490 Prchal Road, Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Junior Order Cemetery 04/18/09 | Preston, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL ACUTE INFARCTION 2 Hours /Medical Due to (or as a consequence of): Examiner 20 yrs CORUNARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a Tyes 2 No o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No After this certificate has 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: # 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04-20-2009

State Registrar 31. Date filed (Month, Day, Year)

APR 2 0 2009

136 Lednum MO Snietek 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

09-03244	
Michael Selby	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

nonaci ociby	1- For State Registrar	Certificate o			2009) 4 4 }
Physician/	Decedent's Name (First, Middle,Last)			2. Date of Deat	h	3. Time of Death
Medical Examine	Michael David 4a. Facility Name (if not institution, give street and number	ir)	Selby 4b. City, Town, or Location	Month April 22, 2	4c. County of Death	2131 hrs
	Washington County Hospital	.,	Hagerstown	Washington		
Funeral Director	220-58-4481 1XM 2_F	sge (In yrs. last birthday)	Months Days Hour	o Atio	h(MM/DD/YYYY) 9. Bir Foreig 25,1952 Co	
any	Usual Residence of Decedent 10a. State - 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits
*	MD Washington	Hagerstown	1			1 Yes 2 No
n with the Maryland ms 23a or 28a-f sho he notified at once eral Director			10f. Zip Code 21740	10	Og. Citizen of What Coul	ntry?
or death	1 2 Midowod 1 A Divorced III Yes Give Year	s? If	Vas Decedent of Hispanic Or Yes, specify Cuban, Mexical Yes 2 X No specify	n, Puerto Rican, etc.)	White, etc.	ican Indian, Black,
5-0036 led within 72 hours afti Hygiene. to ther than "natural" the Medical Examine Completed by		during	ent's Usual Occupation (Give		16b. Kind of Business/I	Industry
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21215-0036 ould be filed within 72 I Mental Hygiene. s marked other than " ic event, the Medical TO Be Complet	Charles William Selby			ta Marie Rep	-	
MD 21 nd 2 should alth and Me an 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) Keith A. Selby/Son 20a. Method of Disposition	393	Universe Dr.	, Martinsbur	g, WV 2540	04
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental I important: Ufrem 27 is marked injury or other traumatic event, To Be	1 Burial 2 X Cremation 3 Removal from S 4 Donation 5 Other Specify:	State crematory or c	osition (Name of cemetery, other place) rg Crematory	Date 4/28/2009	20c. Location - City or Smithsburg	
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee		Name and Address of Facility	Kest Have	n Funeral C	
Physician	23a, Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death. Do not enter	the mode of dying, such as	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical kaminer	Immediate Cause (Final disease or condition resulting in death) a. Atherosc Due to (or as a con		liovascular d	isease		Death
er	Sequentially list conditions, if any, leading to immediate b	sequence of):				
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a con	sequence of):				
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'60, sate be execu physician and he burial - tra	IF FEMALE: 23c. If yes, outon	ome of pregnancy	, 8071 3/11/0		23d. Date of delivery	,
Division of Vital Records, P.O. Box 687(To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/A	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 F	etal death 3 Ectop Other (Specify)	ic pregnancy		Day Year
ires that the case and the detached detached detached detached detached detached detached detached detached by Ph		ath but not resulting in the	underlying cause given in P	Part I. 23e. Did to	bacco use contribute to	
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Division of Vital Records, lal or Attending Physician: The law requirer is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed				24a. Was a autops perform 1 🗸 Yes 2	sy prior to d m <u>ed</u> ? death?	topsy findings available completion of cause of
Vital Recc ysician: The la his certificate ha director, page 2	25. Was case referred to medical examiner?		0,,,,	(Check only one)		
of Vit ling Physic After this (funeral dire	27. Manner of Death 28a. Date of In	ient 2 ✓ ER/Outpatier ijury 28b. Time of	3		Residence 6 Other Ow injury occurred	:
ion trendin leath. tor: A the fun	1 X Natural 5 Pending 2 Accident Investigation	(Year)	1 Yes 2	No		
Division o spiral or Attending nours after death. neral Director: Afte filled in by the fune Certification:		Injury - At home, farm, str	eet, factory, office building, e	etc. 28f. Location (S or Town, St	treet and Number or Ru ate)	ral Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or investig	- ·		• •	
¥ Color	29b. Signature and title of certifier	ND	29c. License number		29d. Date signed (Mor	nth, Day, Year)
h	30. Name and address of person who completed cause of	death (Item 23a)	O.C.M.E.		April 23, 2009	
	Russell Alexander MD. Assistant Med	,	1 Penn Street, Baltim	ore, MD 21201		
State Registrar		rar's Signature	a. el. J			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 11:45AM 04 200 David Thomas 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Owings MD 8415 Stevens Rd If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Aug. 24, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax 1XM 2□F MD 579-22-6000 Yrs. 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD 0wings Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20736 8415 Stevens Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No 194 11. Marital Status Black, White, etc. 1942 1945 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 AWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Topology Technician Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace McIntyre Thomas, Sr. David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Owings, MD 20736 8415 Stevens Road Tyrone Thomas/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/21/2009 Cheltenham, Chelt. Vet. Cem. 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Sewell 1451 Dares Beach Rd. Prince Frederick, MD Funeral Home 21. Signature of Funeral Service Licensee Blades a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of) ement Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Day Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 26. Place of Death Check onl one Other: Hospital:

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit P.O. Box 68760, signed by the a d be detached f Division of Vital Records, icate has been sig ; page 2 should b certificate After this certification death. Director: within 24 hours a filled To the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

Director

Funeral

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Be Completed

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of 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. T? Is marked other than "natural", or Items 23s or 28s-1 show traumatic event, it is believed.

permit. Pages 1 and 2 st Department of Health and Important; If item 27 Is m any injury or other traum QDG.

Physician

illed within 72 hours after Hygiene. other than "natural", or Ite

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be examiner? 4 ☐ Nursing Home 5 X esidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. escribe how injury occurred 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 □ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year) 29b Signature and title of certif 29c. License number

Jeru

31. Date filed (Month, Day, Year) State Registrar

30. Name and address

228 Marrimac Dr Kaymon A. Noble MD 32. Registrar's Signature APR 16 2009

operson who completed cause of death (Item 23a) (Type, Print)

Prince Fred, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Xuong T. Tran 2. Date of Death ^{Day} 2009 Year Month 9:57a M April 14, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 29, 1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 218-19-0447 77 Viet Nam Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Silver Spring Montgomery 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 USA 1400 Ferwick Lane, Apt. 905 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Race - American Indian, Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Asian Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) De Luona Quyen Tran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1400 Ferwick Lane, Apt 905, Silver Spring, MD 20910 Que Ly / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery April 19, 2009 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Lung Disease Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No Month Day Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3XXProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Department of Important: If it any Injury or conce.

Physician

/Medical

10a. State

Director

Funeral

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Completed

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MD

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertial Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show up or other than uny or other than uny or other than and event, II in Marical Event, in course to with his 2

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-trar signed by t I be detach certificate has been s rector, page 2 should director, Certification: To this After thi within 24 hours after death

To the Funeral Director;
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

the

2

Division of Vital Records, P.O. Box 68760,

Physician/Medical ⋧ Completed Be

Medical

1 Yes 2 XNo 27. Manner of Death 1 Watural 2 Accident

one)

6 Could not be determined 3 Suicide 4 Homicide

29a, Certifier (Check only

29b. Signature and title of certifier

5 ☐ Pending investigation

and manner stated.

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

D56691

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

April 15, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12107 Heritage Park Circle, Silver Spring, MD 20906

State Registrar

31. Date filed (Month, Day,

Chousia Sultana

32. Registrar's Signature

	-	For	State of Maryla	•	artment of H			- 21111	14151
		Registrar 1. Decedent's Name (First, Middle,	Last		il lineate of L		2. Date of Death	g. No:	3, Time of Death
Physicia			Elizabeth He	enson	Tavlor		Month April	13, 20	09 12:24 PM
/Medica	_	4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of D	
Examine	er	Baltimore Was		. Ctr.	Glen	Burnie			Arundel
Funeral Director		5. Social Security Number 577-36-2258	6. Sex 7. Age (In yr. 1	s. la <i>st birthd</i> ay Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/11/	^{Year)} 1928	Birthplace (State or Foreign Country) Virginia
	ŀ	Usual Residence of Decedent							
rylane how		10a. State 10b. County Virginia Lou	uisa 10c. 0	City, Town or L Miner	ocation a1				10d. Inside City Limits 1 □ Yes 2 🛣 No
e Mar	당	VIIginia box	110a						
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f show umatic event, the Madical Evention roust be netified at	▭	10e. Street and Number 8621 Freder:	ick Hall Road	d	10f. Zip Code	23117		og. Citizen of What United	
deat	by Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
after or its	ΥF	1 Never Married 2 Marrie			1 □Yes 2 □No	Specify:		Specify:	Black
ural"	d b	3 ☐ Widowed 4 ♣ Divorced		169 Dec	edent's Usual Occup	ation		6b. Kind of Busine	ess/Industry
n 72 n "nat	olete	15. Decedent's (Specify only highest		(Giv	e kind of work done of DO NOT use retired	during most of work			
withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Houseke	eper		Domes	tic
other	BeC	17. Father's Name (First, Middle, La				18. Mother's Nam			
uld be Ments Irked	2	Francis l	Henson				e Winst		
nd 2 sho alth and 27 is ma r trauma	ij	19a. Informant's Name/Relationshi		19b. Mai	ling Address <i>(Street a</i> 521 Fred	and Number or Ru erick H	ral Route Number, all Rd.	City or Town, State, Miner	te, Zip Code) al, Va.23117
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual results be neithed at once.	ľ	20a. Method of Disposition X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spi	3 LI Removal from State LI		oosition (Name of ematory or other place Family		Date 8/2009	20c. Location - City Minera	
permit. I Departm Importar any Inju	1	21. Signature of Funeral Service L			22. Name and Addres Thomas P.O. B	ss of Facility SON Cha	pel For	k Union	ra. 23055
	\dashv	23a. Part 1. Enter the disease, or o	complications that caused the de						Approximate Interval Between Onset and Death
Physician /Medical Examiner		shock, or heart fallure. List of Immediate Cause (Final disease or condition resulting in death)	a. ATHERS S Due to (or as a const		one can	DIOVASC	ULAR]	ISEASL ⁵	Onset and Death VEALS
Examiner	Ļ	Sequentially list conditions,	b	amirrar off.					
ted rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons.	equality (i).					
execu	xar	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
cate be executed bhysician and the burial-transit	dical E		d						
g phy as the	edi								
The law requires that the death certifica ate has been signed by the attending plage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time of 9 □ Unknown	etal death 3	B Ectopic pregnanc G Other (specify)	у		23d. Date of Month	,
that the set by detac		Part II. Other significant condition	ns contributing to death but not r	esulting in the	underlying cause giv	en in Part I.	23e. Did tot	acco use contribu	te to the cause of death?
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v req	Completed						24a, Was a	n 24b. Wer	e autopsy findings available
he lar e has age 2	μğ						autops	ned? deat	r to completion of cause of th? Yes 2 □ No
an: T		25. Was case referred to medical	1			26 Place of Dea	1 ☐ Yes 2 th (Check only on		Yes ZLINO
ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ Inpatient 2	▼ ER/Outpat	ient 3 DOA Oth	or:		ence 6 Other	Specify)
ig Ph ter th	T:u	27. Manner of Death	28a. Date of Injury (Month, Day, Year,	28b. Time		y at k?	28d. Describe ho	ow injury occurred	
endin sath. or: Af	atio	1 Natural 5 Pending 2 Accident investiga	ation			Yes 2 □ No			
r Atterder de lirecton by ti	Certification: T	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		t home, farm, : ec <i>ify)</i>	street, factory, office		28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifying	g Physician: To the best of my i	knowledge, de	ath occurred at the ti	me, date and place	e, and due to the c	ause(s) and mann	er as stated.
he Ho in 24 he Fu	Medical	(Check only 2 Medical E	xaminer: On the basis of exam and manner stated.	ination and/or					
To t To t	Σ	29b. Signature and title of certifier	1.00 5)	29c. Licens			9d. Date signed (A	
		1 Who	while	<u> </u>	リジ	1126	F	741L 1	, 200
DB		30. Name and address of person v RAA 31. Date filed (Month, Day, Year)	The completed cause of death (I	tem 23a) (Typ	e, Print) KIC	BRIDE.	R), 3A	ci more	1, 2009 , and 21236
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gna t ure	1				
Registr	ar	MIN T	1 2009 Stenewa	· 19.	parket				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar Jonathan Lowenthal,

31. Date filed (Month, Day, Year)

M.D.,

32. Registrars Signature

110 Hospital Road, Ste. 310, Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Michael A. Vitto 6:50p M April 11 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1**X** M 2 □ F Months 578-28-1402 81 September 23,1927 DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7401 West Lake Terrace #803 20817 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify. Specify: White 3 Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Printer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nicola Vitto Anna Capozzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15107 Interlachen Drive, Silver Spring, MD 20906 Mary T. Anastasi / Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Remova/from State April 16, 2009 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation ☐ Other (Specify) 21. Signature Freneral 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final immediate Acute Myorardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery cedent pregnant ast 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 ☐ Other (specify) 2 INO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22000 1 □ Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner and trar P.O. Box 68760

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once.

Physician

/Medical

Examiner

Funeral

Director

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28a-f

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items 23a

6

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72 hours after

3, War y...
1 and 2 should be filed within /2
"- and Mental Hygiene."
"- and Mental Hygiene."

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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traumatic event, the Medical Examinar must be notified at

signed by the attending physician be detached for use as the burial has this

Physician/Medical <u>۾</u> Completed Be Certification: To

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requires that the death certificate be spital or Attending F nours after death. neral Director: After y filled in by the funera

Records,

of Vital

Division

IF FEMALE:
23b. Was dec
in the pa

1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death

Hospital: 5 ☐ Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D22775

29d. Date signed (Month, Day, Year) April 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Barr 5454 Wisconsin Avenue Suite #1345, Chevy Chase, MD 20815

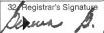
State Registrar

Medical

31. Date filed (Mc

6 ☐ Could not be

determined





To the Hospital within 24 hours a To the Funeral C completely filled Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar	Glate of Mic	ir ylarla / L	•	ficate of D				009	14154
	Physici	an	1. Decedent's Name (First, Middle, La.		, , , , ,				2. Date of Dea Month April 1		Year	3. Time of Death
	/Medic	al	David Car 4a. Facility Name (If not institution, giv		yvill_		Ih City Town or	Location of Death		7	unty of Death	10:08 A.M
	Examin	ier	Anne Arundel Medical Center Annapolis Anne Arund								nde1	
	Funeral Director		5. Social Security Number 6. S		(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10/18/1	. Year)	9. Birth Cou Ma	place (State or Foreign ntry) ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Local	tion					10d. Inside City Limits
	Maryli f sho	tor	MD Anne Ar	rundo1	•	thia						1 □Yes 2 VNo
	n the	Director	10e. Street and Number	under		LIIIA	10f. Zip Code		1	10g. Citizen	of What Cou	ntry?
	23a c	ral D	1041 Marlboro	Road			20	711			U.S.A.	
	er des items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa If Y	s Decedent of His es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mydical Exercity to ust by notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 Yes 2 N If Yes, Give Year or Dates:			Yes 21 No	Specify:				nite
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_	40 = 0 =	Be C	17. Father's Name (First, Middle, Last))				18. Mother's Nam	e (First, Middle,	Maiden Sur	rname)	
<u>yla</u>	should be f and Mental s marked o	To			yvill,			Shir		Ann	Buc	
Mar	12 sh th and 7 is m traum		19a. Informant's Name/Relationship (17	_		nd Number or Rui		-		,
ē,	1 and Healt tem 2		Jason W. Wyvill,	son			O Flande ion (Name of lory or other place	rs Lane.			20776 ion - City or To	
ē	Pages ent of nt: If i		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1			etery 04	/15/09	Unne	r Marll	noro MD
altimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.	-	21. Sommue of Funeral Service Licer		111111			s of Facility Ra				
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	Physician	i A	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause	one cause on each lin	e.		the mode of dying		or respiratory an	rest,		Approximate Interval Between Onset and Death 12 Mow
	/Medical Examiner		resulting in death)		a consequence		700	C 114-1				12 110012
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68760,	ate be	Medical		d								
9 ×	ding p		IF FEMALE:	23c. If yes, outcome of	of pregnancy							
O. Box	The law requires that the death cer ate has been signed by the attendir age 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death		ctopic pregnancy other (specify)			23d	Date of delive Month	ery Day Year
ر. ح	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	n the unde	erlying cause give	n in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
ğ	equire en sig ould b	ed b	Lipid Mr.	nosimality					1 🖎 Y	es 2 🗆 N	√o 3□ Pro	bably 4 🗌 Unknown
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Vita	nding Physician: th. After this certification funeral director, is	Be (25. Was case referred to medical examiner?	Magaital			Lou	26. Place of Deat	h (Check only or	ne)		
0	Physic ruthis or ral dire	 10	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatient	3 DOA Otne	r: 4 Nursing Ho	ome 5 Resid			fy)
0	th. : After	tion	1 ♣ Natural 5 Pending 2 Accident investigation	(Month, Day	(, Year)	njury	28c. Injury Work? M 1 🗆 Y	es 2 □No	200. Describe III	ow injury oc	Scurred	
Division	al or Attending Physician: s after death. I Director: After this certifics id in by the funeral director, s	Certification:	3 Suicide 6 Could not by 4 Homicide determined		ry - At home, far . (Specify)	rm, street	, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rur	al Route Number,
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical (29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner sta	examination an	e, death o	ccurred at the tim stigation, in my op	ie, date and place pinion, death occur	, and due to the orred at the time, o	cause(s) an	nd manner as ace, and due t	stated. o the cause(s)
	To the Comp	Me	29b. Signature and title of certifier	Dai			29c. License		2	29d. Date si	igned (Month,	
			Karnel	D woon	-1 m		1)38	3563		Apri	110,	2007
dr	W2		30. Name and address of person who	Baum	134	(Type, Pri	1/	b RD.	West	RI	ver v	90
	Sta Registr		31. Date filed (Month, Day, Year)	4 2009	Signature	B.	Sparker					

DHMH 17 Rev 1/2001

1 - For State Registrar

	Physici		1. Decedent's Name (F Albin Rich									April		2005	ar	3:35 pM
1	/Medio Examir		4a. Facility Name (If no	ot institution, give	street and num	ber)								County of [
=			8205 Sycar	nore Cir				Owi	ngs r 1 Year	If Under	24 112	0 D-1(D'		Calver		
	Funeral Director		5. Social Security Num 214-24-53	13 6. Se	X X M 2 □ F	'. Age <i>(In yrs</i>		Months		Hours	Min.	8. Date of Bir Month, Da 03/13/	1929	9.	Count	ace (State or Foreign ry) MD
	pc ,		Usual Residence of De												140	d. Inside City Limits
	Marylaı i-f show	ţoţ		ob. County Calvert			ity, Town or ings	Location								1 ☐ Yes 2 🛣 No
	ith the	Funeral Director	10e. Street and Number 8205 Syca				_		p Code				0	izen of Wha	t Count	ry?
	eath w	eraj		amore Ci	12. Was Deced	lent Ever in I	IS 1		736	isnanic Ori	igin? (Sp	ecify Yes or No	US	14. Race -	America	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inspectant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, It. It. offer Existent cust by could a sonce.		11. Marital Status 1 Never Married		Armed Ford 1 X Yes 2 If Yes, Give	es? 2 No 19	46	If Yes, spe		Specify:		ecify Yes or No Rican, etc.)		Black, V	Vhite, e	
9-9	2 hour	ted	15	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Bu								nd of Busin	ess/Ind	ustry		
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Maryland	ould be fi Mental I arked ot atic evel	To Be	17. Father's Name (First, Middle, Last) 18. Mother's									a Stemp				
	1 and 2 should Health and Mer em 27 is marke		19a. Informant's Name/Relationship (Type. Print) Charles Wisniewski (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3392 W. Falling Creek St. Lewes, DE 19958								Code)					
Baltimore,	Pages 1 and ment of Head the state of Head the state of t		20a. Method of Dispos		Removal from S	20b.	Place of Dis cemetery, c	sposition (Na rematory or	me of other plac	ce)	Apri	1 13		ocation - Cit		
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Ba	perm Depa Impo any i	21. Signature of Eneral Service Licensee MO1464 22. Name and Address of Signature of Eneral Service Licensee MO1464 8125 Southern														
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68760,	death certificate be executed e attending physician and d for use as the burial-transit		resulting in death, Las	" [Due to (c	or as a conse	quence of):									
.89	ertificating physes as the	ician/Medical	IF FEMALE:													
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P.O.		Physic	1 □Yes 2 □ N 9 □ Unknown	lo	9 Unkno		ueam									
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Vital	i ician : Th certificate ector, pag	Be Co	25. Was case referred	I to medical					-	26. Place	e of Deat	1 ☐ Yes		1	Yes	2 □ No
f∨i	hysician: his certifica I director, p	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Ir	patient 2[☐ ER/Outpa	tient 3 🗆 D	Oth	or:		me 5 Resi		6 □Other	(Specify	y)
n of	ing P	on:	27. Manner of Death	5 ☐ Pending		f Injury n, <i>Day, Year)</i>	28b. Tim Inju	у	28c. Injur Wor	k?		28d. Describe	how inju	ry occurred		
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		☐ Certifying Ph ☐ Medical Exam		sis of exami										
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		30. Name and address of person who completed cause of death (Item 23a) (Type, Print							D26358 AFRIL 13.2009					.2009		
de	W 6+1		1	s of person who d . Weige					ve Pı	rince	Free	derick,	MD	20678		
	Sta Regist		31. Date filed (Month,		32. Re	gistray's Sign		. Sa	a the s	7						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

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Physician

Examiner

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Director

28a-f show

Director

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Completed

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Examiner

Physician/Medical

Completed

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Certification: To

Medical

IF FEMALE:

1 ☐ Yes

29a. Certifier

29b. Signature

(Check only one)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Whotal Eventher marked any once.

Physician

/Medical

Examiner

and burial-trar

been signed by the attending physician should be detached for use as the buria

has

/Medical

10a. State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5.35 AM Wilkins Elizabeth 5 2009 04 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Salisbury Coastal Hospice at the Lake Wicemice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🔀 F 213-22-7276 82 05/10/1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 □ No Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 602 Manor Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) women's fashions owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Beauchamp Frederick Glasgow 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 602 Manor Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Vernon Wilkins Sr/spouse Date 20c. Location - City or Town, State 20h Place of Disposition (Name of 20a. Method of Disposition Wicomico Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licenses 91 Lampson CFSP Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10001 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 E Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 ROther (Specify) 1050 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

within 2. To the

Registrar

State

31. Date filed (Month, Day, Year)

APR 17

7 Mue 32. Registrar's Signature

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14° 2009 2009 4:30 P M Belva Weber 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Shady Grove Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 10,1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 □ M 2 1 F Months 94 264-63-3812 Texas Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 No Gaithersburg Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 18 Duvall Lane 20877-1838 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Frank Crabtree Anna Maud 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Duvall Lane Gaithersburg, MD 20877-1838 Donald L. Weber/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition St. Mary Queen of Peace 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mechanicsville,MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hysong Company 21. Signature of Funeral Service Ucensee w. 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARREST CARDIAC disease or condition resulting in death) Due to (or as a consequence of): 5EPSIS PNEUMONIA Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CLOSTRIBIUM DIFFICILE COLITIS 24b. Were autopsy findings available prior to completion of cause of death? HYPOTENSION 24a. Was an autopsy performed 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 🗹 No 26. Place of Death (Check only one) Hospital:

Physician /Medical **Examiner** and

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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id 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Medical Examination in the profile of a strain or in the continuous control of the contro

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permit. Pages 1
Department of H
Important: If iten
any injury or ott

Baltimore, Maryland 21215-0036

/Medical

Physician/Medical ģ Completed æ ၉

Medical

State Registrar

Examiner burial-transi attending physician for use as the buria peen : has Certification:

signed by the a' certificate

The law requires that the death certificate be executed Box 68760, o ۵ of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

To the	within	To the	
		3)

Sequentially list conditions, if any lead in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier

2. Registrar's Signature 31. Date filed (Month, Day, Year) WITT .

Machan

D0062562

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-9901 Medical Center Drive, Rockville, Md. 20850 Hubbly

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Moran Burke 2009 Jane A^M May 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 💢 F Yrs. 67 270-28-4479 September 29, 1931 Ohio Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 5811 Edson Lane, 20852 United States items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or if Yes, Give Year or Dates 1 ☐ Yes 2 X No þ Specify: Specify: 3 ☐ Widowed 4 🖔 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Financial Comptroller Hotel Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I em 27 is marked of Clarence Alexis Moran Marguerite M. Carney ၉ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Meghan B. Burke / Daughter 21 Lee Street, Marblehead, Massachusetts 01945 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
any injury or o
once. Jo 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. ieva M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Fart 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous Cell Lung Cancer Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Cardiopulmonary Arrest burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed cate has t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{D} \) Residence \(6 \) Other (Specify) 1 Nation 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpati 1 TYes 2 No this Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 ☐ Pending investigation spital or Attendi lours after death. heral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Division of Vital Records.

within 24 hours a

To the Funeral I

completely filled

State Registrar 29a. Certifier

29b. Signature and title of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Purnima Joshi, M.D. \$2. Registrar's Signature 31. Date filed (Month, Day, Year)

MAY 0 4 2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mynner stated.

29c. License number

D19563

29d. Date signed (Month, Day, Year)

May 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Leo A. Borah, Jr. 26, 2009 4:45AM /Medical April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery <u>Bethesda Health & Rehabititation Center</u> Bethesda 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1**∑**M 2□F Min Months Days Hours Director 578-22-6740 83 May 29, 1925 Washington Usual Residence of Decedent a or 28a-f show t be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 1 ☐ Yes 2 No Director Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a o death Funeral 10201 Grosvenor Place #204 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify. þ 3 ☐ Widowed 4 X Divorced White ithe Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Elementary/Secondary (0-12) College (1-4or 5+) 4 Chemical Society Writer 7 is marked other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo A. Borah, Sr. 2 Juanita Frederick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Geoffrey Borah/ Son <u>1755 Preston Road, Alexandria, Virginia 22302</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State Mav permit. Pages
Department of
Important: If Its
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA NECK **Physician** SOUAMOUS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 certificate 1□ Yes Division or Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Directory filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Function

completely 1 (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

MAY 0 4 2009 DHMH 17 Rev 1/2001

Truong Bao, M.D. 31. Date filed (Month, Day, Year)

00057124

10110 Molecular Drive, #206, Rockville, Maryland 20850

4129109

lupsed, us

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} 29, 5:15 2009 <u>April</u> Lynwood D. Bennett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase Manor Care-Chevy Chase If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (in yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Yrs. Jan. 16, 1929 Washington, D.C. 80 579-84-1913 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20012 7723 Alaska Avenue, N.W. #201 United States 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ∏Yes 2**½** No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 6 N<u>one</u> None Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental H 1 and 2 should be the Health and M Clifton Monroe Bennett Margaret Evelyn Thompson ဥ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7723 Alaska Avenue, NW #201, Washington, D.C. 20012 <u>Frederick W. Bennett/Brother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 5 Goshen Cemetery Gaithersburg, Maryland 2009 Robert A. Pumphrey Funeral Home, 21. Signature of Funeral Service Licenses Bethesda-Chevy M00198 7557 Wisconsin Ave. Rethesda, MD 2081423501.

23a. Parti Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unicated on injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Division or Vital Records, P.O. Box 68760, & and Due to (or as a consequence of): physician Physician/Medical the as led by the attending detached for use as IF FEMALE 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours aft e Funeral D letely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the

State Registrar

29b. Signature and title of certifier

9801 Georgia Avenue #1-17, Silver Spring, Maryland 20902 Sunitha Bhogavilli, M.D. 31. Date filed (Month, Day, Year) MAY 0 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

29c. License number

D54566

29d. Date signed (Month, Day, Year)

April 29, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear **Physician** Burwell-Phifer 5:00p. Etta Rebecca 04 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4717 West Forest Park Ave
5. Social Security Number 6. Sex 7. Age (In yr Baltimore
1 Year | If Under 24 Hrs. If Under 1 Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2√□ F **Director** 104 217-48-2518 09 03 1905 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a U.S.A. 4717 West Forest Park Ave 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 □ No Specify: ģ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Douglas High School Teacher 12th grade is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f π and Mental F Etta Diggs Caliborne Burwell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is n any Injury or other traus Kettering, Md 20774 Edith Young-Cousin 11904 Wimbleton Street, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 5/5/09 Woodlawn, Md 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Par 1. Enter th Jusease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shruk, or heart failure. List only one cause on each line.

Immediate Cause (Find Cause (Find Cause Condition)) 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Acute Ceresnol Usicolar seciéen **Physician** 3 Yzwerky disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Mementia and Due to (or as a consequence of): Box 68760. attending physician for use as the buria HEAVERIESE Lesemie Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No P.O. the 9 I Inknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ronse Bronchizi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician; The it Upertension certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 □ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ို 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lary J. (Erry 1 - 2116 Mary) 10 V 2116 May (md ave Ballo, Md-21219)

State Registrar 31. Date filed (Month, Day, Year)

MAY 04

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland		artment tificate			nd Me	ental Hygi	ene	009	14163
			Decedent's Name (First, Middle, I	ast)		-					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Charlotte	F. B	urgee					I I		28,	2009	1:15 p ^M
	Examin		4a. Facility Name (If not institution, g	rive street and number	er)		4b. City, To	own, or l	Location of	Death		4c. C	ounty of Death	
			Golden Livin	ng Center					West			<u></u>	Carr	
	Funeral		Social Security Number 6	. Sex 7. 1 □ M 2 🔀 F	Age (In yrs. la		If Under 1 Months I	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign ntry)
	Director		213-16-5656	1 L W 2 C2 N	87	Yrs.					April 1	1, 1	922 Mai	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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	28a	rec	10e. Street and Number				10f. Zip C	Code			10	g. Citize	n of What Cou	ntry?
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	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Jical Examiner must be natilied at	Funeral Director	11. Marital Status	12. Was Decede		S. 13.	Was Deceder	nt of His	panic Orig	in? (Spec	cify Yes or No- lican, etc.)	14	. Race - Ameri Black, White	
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21215-0036	ours iral',	d by	3 XWidowed 4 ☐ Divorced	Year or Date	s:									White
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an	d be natal	Be c	Arthur Peter Go		e r v					Nell	ie Ru	dasi	11	
Maryland	nd 2 should be ith and Mental I	၉	19a. Informant's Name/Relationship		3	19b. Mailir	ng Address (Street a			Route Number,			p Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and I Health and Sae or 28e-1 show ifem 27 is marked other than "netural", or Itamis 23e or 28e-1 show other traumatic event, the Modical Examiner mast be notified at	1	Erma Gill Dav	ughter		203	Bond A	venu	ie Re	iste	rstown,	MD	21136	
Baltimore,	permit. Pages 1 and Department of Heatt Important: If Item 2: any injury or other 1 once.		20a. Method of Disposition		l ce	ace of Dispo	sition (Name matory or oth	e of	1				ation - City or T	own, State
E	Page nt: tf ry or		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		110		ne Par		1	5/1/0)9	Wood	llawn,	Maryland
alti	mit. partm sorta / inju		21. Signature of Funeral Service Lic	censee	-		2. Name and				1824 Rei			
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			2 a. Part1. Enter the disease, or co	omplications that cau	sed the death h line.	n. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
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	/Medical		resulting in death)		as a consequ						•			- 7
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	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c	as a consequ	uence of):								
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687	death certificate e attending phys of for use as the	edic	2	d										
Box (death certifica attending ph d for use as th	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-					23	d. Date of deliv	very
ă	death s atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗷 No	4□Pregnan	n 2 ☐ Fetal It at time of de		⊒Ectopic pred ☐ Other (spec						Month	Day Year
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ū	ler le	on:	27. Manner of Death 1 Anatural 5 ☐ Pending		Day Year)	28b. Time of Injury		lc. Injury Work			28d. Describe ho	w injury	occurred	
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Division	at or Attandir atter death. I Director: Af d in by the fu	ertification:	4 Homicide determin		, etc. (Specify		reet, ractory,	OTHCO		-	City or Town			
	To the Hospital or I within 24 hours after To the Funerel Dire completely filled in b	O	29a. Certifier 16 Certifying	Physician: To the b	est of my kno	wledge, deat	h occurred a	t the tim	e. date an	d place, a	and due to the ca	ause(s) a	and manner as	stated.
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	To th To th comp	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (Month	Day, Year)
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			30. Name and address of person w	ho completed cause	of death (Item	23а) (Туре	Print)		0	, 1-	2 / 1 -		» A	MD 21157
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	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ture 4	Ives 1							(), Day, Year) () () () () () () () () () () () () () () () () () () () (
	Regist	rar	MATUTAL	100	-	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	ai yiaiiu / 1		ficate of L	Death	-	Reg. No.	2009	14164
	Physic	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death
and a	/Medi		Otto Earl Beg						4	ر گ		12:52 PM
	Examir	ier	4a. Facility Name (If not institution, give s 5100. Hapita		Himore	e	Balti	more Cit	7		County of Death	
	Funeral Director		401-32-3799	7. Ag	e (In yrs. last bii 78		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Oct. 13	th 3, 193	9. Birth Con	place (State or Foreign intry) KY
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Locat	tion					10d. Inside City Limits
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	th the or 28: e not)ire	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	ath wi	la l	2414 Crest Road				21209				USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Expresses must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:	No		s Decedent of Hi es, specify Cuba Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White, Specify: Wh:	
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation		. Deceder	nt's Usual Occupa	ation during most of work	ina	16b. Kii	nd of Business/Ir	ndustry
121	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)			furing most of work)	"ig		_	
	iled w Hygie I her ti nt, th		12 17. Father's Name (First, Middle, Last)			Asst	Traine	18. Mother's Name	o (First Middle		orse Rac	ing
Maryland	d be f ental l ced of c eve	Be c	Walter Begley						a Kelly	Walden	ourname)	
Z	should and Mer s marke umatic	욘	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b	b. Mailing	Address (Street a	and Number or Rui		er, City o	r Town, State, Z	ip Code)
	1 and 2 Health a em 27 is		Patricia Begley	Wif	e 2	414 (Crest Ro	ad, Balti	imore, M	4D 21	209	
ore,			20a. Method of Disposition		20b. Place o cemete	of Dispositi	on (Name of ory or other plac	e)	Date	20c. Lo	cation - City or T	own, State
Ē	Pages ment of a ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1			ery 5/5/	/09	Pik	cesville	, MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	e		22. N	lame and Addres	ss of Facility			stersto	
	0.0 ≥ ≈ 0		Kellry D					ral Home			own, MD	
	Physician /Medical		23a. Part Enjer the disease, or compli- shock, or heart failure. List only on the ediate Cause (Final disease or condition resulting in death)	-	the death. Do			g, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death 3 days
7	Examiner	Н		Due to (or as	a consequence	of):						
		ĕ	Sequentially list conditions, if any, leading to immediate		a consequence	of):						
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events									
, 00,	e exectan a		resulting in death) Last	Due to (or as	a consequence	of):						
68760,	rtificate be executed ng physician and as the burial-transit	ledical	d									
O. Box	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[Unknown \]	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		ctopic pregnancy other (specify)	1		2	23d. Date of deli	very Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting in	in the unde	erlying cause give	en in Part I.	23e. Did to		/	the cause of death?
of Vital Records,	The law re cate has be page 2 sho	Completed			-				24a. Was autop perfo 1 □ Yes		24b. Were aut prior to c death? 1 □ Yes	opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	anital (12 13	Lau	26. Place of Deat	h (Check only o	one)		<u></u>
of	di Si	은	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatie		utpatient Time of		4 LI Nursing Ho			6 ☐ Other (Spec	ify)
O	ding T. After funer	io	1 ☑ Naturàl 5 ☐ Pending	28a. Date of Inju (Month, Da	y, Year) 200.	Injury	28c. Injun Work	y at (? Yes 2 □ No	28d. Describe l	now injur	y occurred	
Division	al or Attending s after death. I Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, fa c. <i>(Specify)</i>	arm, street		163 2	28f. Location (S City or Tov			ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	Medical C	29a. Certifier (Check only one) 1	Ician: To the best per: On the basis o and manner sta	f examination ar	je, death o nd/or inves	ccurred at the tin stigation, in my o	ne, date and place, pinion, death occur	, and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier Clasher B	Prato, N	n.D.		29c. License				te signed (Month)	, Day, Year)
1			30. Name and address of person who co	mpleted cause of d	eath (Item 23a)	(Type, Pri	nt)	A 10 1				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	יטי ר	aspital	or Isul,	rimore			
	Registr		30. Name and address of person who co Aushim Rhul 31. Date filed (Month, Day, Year)	Dennika	B. 4	ark						
			THE TENOO	1-1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** a M 29 2009 April 6:16 Margaret Burger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1813 Old Eastern Avenue Essex Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Year 1 □ M 2 🛛 F 1927 Maryland 81 Director 213-24-1024 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Essex 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code rai", or items 23a or Examiner must be r U.S.A. 1813 Old Eastern Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ White 3 X Widowed 4 ☐ Divorced ed other than "natural", event, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Coursey Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 1 Margie M. Vogt, Daughter 2977 Harrogate Way, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery May 1, 2009 Baltimore, Maryland 21. Signature of Funeral Service/Ligensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Dailson un d. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myocardia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, frame and global sequences. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar and P.O. Box 68760, 5 Due to (or as a consequence of) physician Physician/Medical as the IF FEMALE: ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the s detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

10

State Registrar

pecto

29b. Signature and

who completed cause of death (Item 23a) (Type, Print) 2014 32. Registrar's Signatur

29c. License number

Tollgate Rd

29d. Date signed (Month, Day, Year)

Bel Air MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fb 8891 5-4-09 WE State of Maryland Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **BECKLEY Physician** HEI ENE GREIF 27, 5:45P APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SLADE AVENUE #206 BALTIMORE Birthplace (State or Foreign Country)
 MARYLAND If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** 220-44-8572 94 Months Days Hours Min. 1 □ M 2 🕱 F 1915 FEB 1, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" ~ ...
any injury or other traumatic event. 10b. County BALTIMORE 10d. Inside City Limits 10a. State 10c, City, Town or Location BALTIMORE 1 □Yes 2 X No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 1 SLADE AVENUE #206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married 1 □Yes 2 No WHITE Specify: Be Completed by Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WHITEHILL GREIF STELLA DAVID ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rp of quite Number, City or Town, State, Zip Code) 2200 S. OCEAN BLVD. #IOII DELRAY BEACH FL 33483 SUZANNE APPLEFELD/DAUGHTER 20b. Place of Disposition (Name of cemetery crematory or other place)
DRUID RIDGE 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation BALTIMORE, MD 3 Removal from State 5/1/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** omo disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No this certificate 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Medical Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 ☐ Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

6301

Ncharles St, Ste 5,

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2009 Physician 09:05 A M 1 Denis Thomas Cleary May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days New York 1 X M 2 □ F 69 088-30-6189 May 18, Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director North Potomac Marvland | Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number United States 20878 13 Paramus Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11 Marital Status 1 ☐ Never Married 2 X Married White 1 □Yes 2 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Mortgage Company Vice President permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 Is marked other that any injury or other traumatic event, I'm. 1000. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Eustace Denis Cleary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 Paramus Court, North Potomac, Maryland 20878 Wendy Cleary/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. 20a. Method of Disposition May 3, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service License Halow M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Days Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner 1 week Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Months be executed Cardiac Cirrhosis and Due to (or as a consequence of): burialphysician Box 68760. Physician/Medical the attending pl If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I □Yes 2 □ No P.O. the 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 1 Certification: Injury 1 XNatural 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. 2 Accident I or Attend after death Director; 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours all To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2☐ Medical E completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a May 1, 2009 D0066416 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 9701 Medical Center Drive, Rockville, Maryland 20850 Ramaseshan, M.D. Sajatha

State Registrar 31. Date filed (Month, Da

0 4 2009

Day,

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** ELMER 2145 EDWIN COLLINS 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Gree Advantist Hospital Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 1, . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 86 Maryland 214-18-8388 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20850 United States 106 Mannakee Street filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 1944-14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 🛛 No If Yes. Give 1946 þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 1 and 2 should be filed withir Health and Mental Hygiene. em 27 is marked other than Construction Company Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Purvis Elmer Collins Edwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Mannakee Street, Rockville, Maryland 20850 item 27 i Edith L. Collins / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 May 8. permit. Pages 1 Department of H Important: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2009 Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Vette Bar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Rend 2days Aute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Fibrilla hon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☑No 24a. Was an cate has t autopsy certificate 1 □Yes 2 12 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 1 No After this c funeral dire 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending within 24 hours arter com.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Nguyen,

9901 Medical Center

DOU 63163

Drive

May 01, 2009

Ruculle MD 20850

Examiner death certificate be executed Box 68760. Ö Division of Vital Records,

Examiner and attending physician for use as the burial Physician/Medical the detached signed by to be tach Completed has page 2 within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page Be ို Certification: Medical

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

items 23a

'natural', or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental

Physiclan

/Medical

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "Medical Examinar in ust be 1 cilling at

Baltimore, Maryland 21215-0036

by Funeral Director

Completed

the Hospital or Attending Physician:

State Registrar 29b. Signature and title of certifie

29c. License number D64395 29d. Date signed (Month, Day, Year)

AFRIL 28, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEMARUS ST, SUITE 200 BALTIMICE, MD 21204 DOBERMAN MO 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 30 Physician 20:17 PM 2009 Evelyn Mae Clark /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min 1 □ M 2 🛛 F Yrs. 62 10/19/1946 Director 214-44-5324 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the "ted call Examiner must be retilled at 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3206 Stanley Road 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Communcation Specialist Retirement Community 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events. Dennis Joseph Knight Viola Fincham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard H. Clark / Husband 3206 Stanley Road, Baltimore, MD 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XIBurial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 5/5/2009 Elkridge, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. of Funeral Service Licansee 21. Signatu 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** otherosphero cord ovascul /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No al or Attending Physician: Ts after death.
Il Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \) (Specify) Yes 2□No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital ο 24 hours aft e Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0033061

State Registrar 31. Date filed (Month, Day, Year)

gras those tal Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month A^{M} 30, 2009 7:45 April Patricia S. Dassori 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery #604 3330 N. Leisure World Blvd. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F Washington, D.C 72 April 29, 1937 213-38-4865 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20906 3330 N. Leisure World Blvd. #604 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Montgomery County Government Computer Analyst/Programmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Edward Swaim Esther Naomi Roll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy M. Williams/Friend 10 Frantz Court, Fredericksburg, Virginia 22405 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service License M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Respiratory Failure l week disease or condition resulting in death) Due to (or as a consequence of): 2 vears Neurological Weakness Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Two by for as a graps whance offer Amyotrophic Lateral Sclerosis years Due to (or as a consequence of):

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760, attending p

Physician

/Medical

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Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner s been signed by the should be detached Medical Certification: To Be Completed by has e 2 s certificate ha After thi funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. I	Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknow
		Was an autopsy available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check o	nly one)
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5X	Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	ribe how injury occurred
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		on (Street and Number or Rural Route Number, r Town, State)
29a. Certifier 1 ★ Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to miner: On the basis of examination and/or investigation, in my opinion, death occurred at the t	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aniless

and manner stated.

18111 Prince Phillip Drive, #202, Olney, MD 20832

29d. Date signed (Month, Day, Year)

April 30, 2009

Oliver James Lawless, M.D.

29c. License number

D25410

31. Date filed (Month, Day, Year) MAY 04 2009

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #8 per FH g891 5/4/09 11
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 200 Gar Day **Physician** ELLA MAY DAVIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FSURNIE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, ANNE GLEST UNDEL 8. Date of Birth (Month, Day, 10/27/ Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Hours 215-12-7143 85 Director Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h County 10a. State d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination to be inclified at 1 ☐Yes 2 No Completed by Funeral Director Anne Arundel Pasadena MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 121 Riviera Drive 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Lillian McCord ဥ Raymond Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1312 Roe Road, Sudlersville, MD 21668 <u>Lawrence</u> Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Pk 05/07/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Se ce Licensee Riviera Drive, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit mast. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes/ 2 No 1 🗹 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending 1 □Yes 2 □No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Prints AAAATO 201 Hochiful Dvive 4 20161 Mi) Hospital Drive ONAGA Tο 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 5:30 A M LAWRENCE DANIEL DRANE, JR. Mav 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arundel 7875 Elizabeth Road Pasadena Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/1950 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Hours 1 **Z**M 2 □ F Days 58 Maryland 213-48-9849 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Pasadena Anne Arundel 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 7875 Elizabeth Road 12. Was Decedent Ever in U.S. Armed Forces? 1971 – Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: White 1972 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel County Elementary/Secondary (0-12) College (1-4or 5+) School Board 12 Chief Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence_Daniel_Drane, Sr. Audrey Louise Hoos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7875 Elizabeth Road, Pasadena, MD 21122 <u>Sally Drane</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 105/04/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Paneral Service Licensee <u>169 Riviera Drive, Pasadena, MD 21122</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiac ar disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death?

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Hyps	lifo Le mug	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No		
25. Was case referred to medical	26. Place o	of Death (Check only one)		
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs	sing Home 5₭ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred		
3 ☐ Suicīde 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 Certifying Ph	i ysician: To the best of my knowledge, death occurred at the time, date and	I place, and due to the cause(s) and manner as stated.		

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Len Burnie owers 31. Date filed (Month, Day, Year)

DALTIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

(Check only

29b. Signature and title of certifier

SAWHNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 la Theresa Daley /Medical county of Death 4b. City, Town, or Location of Death 4c. 4a. Facility Name (If not institution, give street and number) Examiner lest Housville IMOr OWY | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | March | 14, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) 1911 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕱 F Yrs. 218-28-0320 Ireland 98 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Exprainer must be retiffed at 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21228 715 Maiden Choice Lane, Cr 202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Thornton John McHale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Mojzisek / Daughter 4005 Pinedale Drive, Baltimore, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Noseph, Fullerton 05-07-2009 St. Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications in a c shock, or heart failure. List only one cause on as Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final men 6443 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 sl autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ N 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ပ္ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident reral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Choice Ne

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Registrar

31. Date filed (Month, Day,

MAY 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0335 **Physician** Evans 2009 Dorothy MAY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) GLEN BURNIE WASHINGTON MEDICAL ANNE ENTER GLEN R 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Min. Days Hours 1 □ M 2 🙀 F 212-36-5787 76 10-15-1932 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at GLEN BURNIE MD A.A.CO Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with 7929 FREETOWN ROAD 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xlo Specify BLACK ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH AID 11 HEALTH Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, If once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES THOMAS MORTON **GLADYS BRYANT** ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 474 RENFRO CT., GLEN BURNIE, MD 21060
sition (Name of Date 20c. Location - City or Town, State VANESSA JOHNSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State KING MEM. PARK 05/11/09 BALTO., MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Si w ture of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cespirator hour /Medical a consequence of): Examiner Arollac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit - 7 days-rend Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 10-11005-C Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 🖫 Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: Certification: To 1 Tes 2 XNo 1/≅ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) inter Medical 11 73h0 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	State of Maryland / Department	rtment of Health and Me rtificate of Death	ntai Hygiene Reg. No	0000 11176		
_			1. Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death		
	Physicia	an	PAULA EMBRSON		Month Da	9 11:17 PM		
market.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	40	: County of Death			
1			UNIVERSITY OF MD MEDICAL CENTER	Data of Disth	Birthplace (State or Foreign			
	Funeral Director		5. Social Security Number 265-04-3492 6. Sex 1 M 2 TF 57 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year) 4/26/19!	9. Birthplace (State of Poleight) Country) WW		
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits		
	Maryl:			altimore		1 A¥es 2 □ No		
	with the 1 3a or 28a-	al Director	10e. Street and Number 1804 Sexton Street	10f. Zip Code 21230	_	itizen of What Country? JSA		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Examination and once.	by Fui	1 Nover Married 2 M Married 1 TYes 2 No	Was Decedent of Hispanic Origin? (Spec if Yes, specify Cuban, Mexican, Puerto Ri 1 □Yes XXNo Specify:	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: white		
15-0	in 72 hou n "natura	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)		Kind of Business/Industry		
212	d with giene gr tha	ĕ	Elementary/Secondary (0-12) College (1-4or 5+) 1.2 College (1-4or 5+)	ashier				
p	tal Hy d othe	Be C	17. Father's Name (First, Middle, Last) Luther Spaulding	18. Mother's Name (First, Middle, Maide June F			
yla	ould t 1 Men 1 arke 1 atic	유		ng Address (Street and Number or Rural				
, Mar	and 2 sh ealth and 7 7 is n er traun		Raymond K. Emerson /Husband 18	01 Sexton St., B	altimore	e MD 21230		
Baltimore, Maryland 21215-0036	Pages 1 and of He		20a. Method of Disposition 1 □ Burial 2 ⊕ Peremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Dispocemetery, cre-	osition (Name of Damatory or other place) Crematory 5/4/		nover Maryland		
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee Victor Doda	2. Name and Address of Facility narles L. Steven 501 E. Fort Aven	s Funera ue, Bal	al Home, Inc. timore MD 21230		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death		
4	Physician		Immediate Cause (Final disease or condition	FAILURE		Officer and Death		
أري	/Medical Examiner		resulting in death) Due to (or as a consequence of):	CERCIC				
	LXaiiiiici	'n	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	AL JUSIA				
16.	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	US FISTULAS		-		
Ć	exect an and rial-tra	Exa	resulting in death) Last Due to (or as a consequence of):					
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89 J	ertifica ling ph e as th	Med	IF FEMALE:			20d Date of delivery		
O. Box	that the death certificed by the attending I detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
σ.	Physician: The law requires that the this certificate has been signed by the rall director, page 2 should be detach		Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?				
rds,	iw requires that s been signed t should be deta	d by	SQUAMUS CELL CARRINAMA OF TO	MGVE	1 ☐ Yes	2 No 3 Probably 4 Unknown		
Vital Record	e law rec has bee e 2 shor	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
Ä	The la	E O			performed 1 □ Yes 2 🔀	death?		
/ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death	`			
of \	Physic rthis c	은	1 ☐ Yes 2 ☐ No ☐ Tospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne 5 Residence	6 ☐ Other (Specify)		
n C	Jing J. After fune	ion	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	.00. 00001100 11011 11	,u., y ooduou		
Division	Hospital or Attending 24 hours after death. Funeral Director; Afte stely filled in by the fune	Certification:	2	28e. Place of Injury - At home, farm, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
_	To the Hospital or Attenomitin 24 hours after death To the Funeral Director:	Medical Co		ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
	•		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		stril any		
	2		30. Name and address of person who completed cause of death (item 23a) (type Awy 17 i Fell 22 S. Gra	ene St. Baldina	, NO 2	1201		
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		(,		
	Regist	rar	MAY 0 4 2009 Sentin B. Ja	all of the second				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AGNES HOSPITAL 1 Year Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Social Security Number (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 578-80-6765 Months Days Hours Min. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 □ No Baltimole Director 10g. Citizen of What Country? 10f. Zip Code Street and Number 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Harford Belair Haven Hoogram Maintenance (First, Middle, Maiden Surname) Tather's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1818 Bolton St., Baltimole, M.D. 2121 nformant's Name/Relationship Baltimole, MD 21217

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimole, Green Mount Comptent 05:01:09 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician bronchopneumonia Probable /Medical Due to (or as a consequence of): Examiner unknown Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown anternsepted Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 □ No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Division of Vital Records, P.O. Box 68760,

burial-tran After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After filled in by the

and

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

State Registrar

4 Homicide

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

AVE. BALTIMORE, MD21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON 82. Registrar's Signature

and manner stated.

MAY 0 4 2009

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Item 26 per dr., 8891,05/05/09dnb
State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a, 26 per dr., 8891,05/04/09dnb
Certificate of Death

Reg. No. 2 0 0 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year HARRIS Month **Physician** MARCH 0635 M FNOREW 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWAK ELUMBIA 11036 SWANFIELD
5. Social Security Number 6. Sex LOAC If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□ F 101-20-7611 81 Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f shov injury or other traumatic event, the Medical Evanimer rust be notified at 1 Yes 2 No HOWARR umbik Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21041 11036 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCILLE PIGMON ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. 11036 SWANFIELD ROAD COLUMBIA MD 21044 MINOTT LINDA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-24-09 BROOKLYNI, N.Y. PRESS HILLSCON 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWETL FINIETIML HOM O 21. Signature of Funeral Service Licensee Bulle de 101 15550F MD 20194 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mye ladysplasion **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner memen Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed the attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by volce funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No ser tense 24a. Was an has autopsy performed? 1 ☐ Yes 24 No After this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ter (Specify) 27. Manner T Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 ✓ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death, within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3635 Darr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of F			giene leg. N2 0 0 9	14179
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic	al	Lee Milton Howar						28, 2009 Year	12:30 P M
	Examin		4a. Facility Name (If not institution, give				r Location of Deal	th	4c. County of Dea	
			719 Maiden Choice 5. Social Security Number 6. S		F201 Age (In yrs. last birthday	Catons v	71116 If Under 24 Hrs	8. Date of Birth	9 Bir	-
	Funeral Director			M 2□F	86 Yrs.	Months Days	Hours Min	Nov. 9,	1922 I	thplace (State or Foreign puntry) ndia
	_		Usual Residence of Decedent							10d. Inside City Limits
	anylan show	_	10a. State 10b. County		10c. City, Town or L					1 ☐ Yes 2 ☒ No
	889-11	Director	Maryland Baltimor	e	Catonsvi	.11e			10g. Citizen of What C	ountry?
	with t	Dir	10e. Street and Number 719 Maiden Choice	I and #	201	21228			United Sta	
	Jeath	era	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-		erican Indian,
9	after or Iter	Fur	1 ☐ Never Married 2 🔀 Married	Armed Force 1 Yes 2 If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 No		no rican, etc.)	0	
8	ours LExe	d by	3 Widowed 4 Divorced	Year or Date					W	hite
<u>5</u>	"natu	iete	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Business	Andustry
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	e filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
lan	uld be Menta Irked tic ev	To B	John Anderson How	ard				race Leme		
Maryland	2 sho and ! is ms		19a. Informant's Name/Relationship (- ·		_			r, City or Town, State,	
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201	ages 1 nt of H : #fite		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐		ste cemetery, cre	ematory or other pla emorial Parl			Rockville,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, I'm Medical Evarities in ust be notified at ance.	1	 4 □ Donation 5 □ Other (Specifical Service Liceration) 		1		,_,,		ockville, Inc	
Ba	Depa Impo any i		Buttury	Blint	M01548 3	00 W. Montgo	mery Avent	ie, Rockvil	le, Maryland 2	0850
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau					rest,	Approximate Interval Between
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н	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					
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	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due (0 (0)	TO (or as a consequence or).					I
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	the a	ysicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9∐Unknow		Other (specify) _				
P.0	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	quires n sign uld be	d by						10	Yes 2⊒No 3⊟F	Probably 4 Unknown
Records,	aw requir ts been si 2 should	piete						24a. Was		autopsy findings available completion of cause of
mage de la performed? deal performed? la							rmed? death?			
ita	sicien: Th certificate irector, paç	Bec	25. Was case referred to medical examiner?					eath Check on	one	
The state of things of the state of the stat								ecify)		
						now injury coccined				
isi	deat deat ctor: y the	ficat	3 Suicide 6 Could not b	28e. Place o	f Injury - At home, farm,	7 - 1 - 1	_		Street and Number or i	Rural Route Number,
$\frac{8}{2}$	after after I Dire	erti	4 Homicide	building	g, etc. (Specify)			City or To	wii, Siale)	
6	To the Hospitel or / within 24 hours after To the Funerel Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	miner: On the bas	est of my knowledge, de is of examination and/or or stated.	investigation, in my	opinion, death oc	curred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mo.	nth, Day, Year)
	, , , , ,)	/~	1D	DH.	744)		45 1:JOH	2009
			30. Name and address of person who	completed cause	of death (Item 23a) (Typ	Print) +UNSU1'1(e Mar	y land	And (214
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 4 200	\$2. Re	gistrar's Signature	Med			V	
	riegist	421	עט דע ו אוין	الماساس ل						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine Impart to notified at once.

Baltimore, Maryland 21215-0036

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Physician /Medical Examiner

sician and burial-trans attending physician for use as the burial signed by the a completely filled in by the funeral director, page 2 should has certificate

The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital Hospital or Attending Physician: After this death. 24 hours after deatle Funeral Director: To the I within 2

NA 0611NE

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April 30 2009 3:25 рМ Madeline Margaret 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore** Baltimore Oak Crest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🕱 F Maryland 91 Yrs 217-07-0122 1917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Counts Director 1 ☐ Yes 2 No Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify. þ Specify. White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loretta Mullaney King Lockwood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Fox Rd. Fallston, Md. 21047 Mrs. Carole Ann Klunk/ Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 5-4-09 Timonium, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc 21. Signature of Funer I Service Licensee <u> 1050 York Rd. Towson, Md. 21204</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe peripheral vascular disease, MRSA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed infection, left ankle fracture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred
Missed chair and fell while trying 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 D Natural 2/15/2009/12 noon 1 ☐ Yes 2 🗷 No 2 Accident to catch broath on way to batter com 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number of Piral Route Number, City or Town, State)

28f. Location (Street and Number of Piral Route Number, City or Town, State)

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28f. Location (Street and Number of Piral Route Number)

28f. Location (Street and Number of Piral Route Number of P 3 Suicide 4 Homicide 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Etosha Dixon wallher blud Parkville HD 21234 31. Date filed (Month, Day, Year) 32. Registrar's pignatur State MAY 0 4 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AM 2009 Physician William /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days **Funeral** 69 12/28/1939 Pennsylvania Director 206-30-4291 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Susquehanna Auburn Funeral Director Pennsylvania 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe RR#2 Box 169 18630 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ried 2 Married 4 Divorced 1 ☐ Yes 2 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int; If item 27 is marked other than "natural", or ite 1 Never Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing <u>Technician</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Hall Myrtle Lloyd မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. RR#2 Box 169, Meshoppen, Pennsylvania 18630 Elizabeth A. Hall-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Tunkhannock, R. H. Jones Crematory 05/06/2009 Pennsylvania 22. Name and Address of Facility David J. Weber Funeral Homes PA re of Funeral Service Licenses 401 S. Chester Street Baltimore, Maryland 21231 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Seps.'s

Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical **Examiner** Myeloschous Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence f) nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the at lid be detached for 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 ate has page 2 1 Yes 1 Yes certificate 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 🗌 DOA မ 27. Manner of Death 1 X Natural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No eral Director: A after death. 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Hospital 29a. Certifier Medical (check only one) and manner stated.

State

Robert S. 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

Hagan 32. Registrar's Signature

S /Szym MD/PhD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Registrar

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 12:10 P.M Nona Mae Kocher 2009 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Min. 1 □ M 2 🖫 F Days Hours 29Yrs 215-26-0070 6/5/1919 Director Balt.,Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinal must be natified at once. Maryland Baltimore Timonium 1 ☐Yes 2 No Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 2300 Dulaney Valley Road 21093 of America Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2∑No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No White If Yes, Give Year or Dates: Specify: 3₺Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mulford Peterson Nona White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard S. Chilcoat/ son 17400 Bruehl Road Upperco, Maryland 21155 20b. Place of Disposition (Name of cemetery, crematory or other place)
Prospect Hill
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date May Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Towson, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P
2325 York Road Timonium, Maryland 21093 21. Signature of Juneral Service Icenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final Physician week < disease or condition resulting in death) ment /Medical Due to (or as a consequence of): Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

12:10 P.M

law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Records, P.O. Box 68760 To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, page Division of Vital

MAY

KOCHER

Sequentially list conditions, if any, leading to immediate cure. First confly, Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2, No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☒ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No			
25. Was case referred to medical examiner?		ath (Check only one)			
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4세 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	i hysician: To the best of my knowledge, death occurred at the time, date and placeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
29h Signature and the of certifier	29c License number	29d. Date signed (Month. Day, Year)			

DHMH 17 Rev 1/2001

State

Registrar

2300 DULANEY VALLEY ROAD

TIMONIUM, MD

21093

30. Name and address of person who completed cause of death (Item 234) (Type, Print)

M.D.

32. Registrar's Signature

S. park

ERNESTINE WRIGHT,

0 4 2009

31. Date filed (Month, Day, Year) MAY 0 4 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician A M KNOX Delores B. 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA ALTIMORE AGNES HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ■ M 2 X F MD 214.38.9165 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No 12a etamore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Woodinaton Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: Plank ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Securiti Elementary/Secondary (0-12) College (1-4or 5+) Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Gresnam Greene Samuel မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Stream Wood Drive Baltimore MD 21208 KNOX W/lest 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Baltimore, MD 05/02/09 Western Cemeten 4 Donation 5 Other (Specify) 22. Name and Address & Facility Jaughn C. Steene Funeral SUG 21. Signature of Funeral Service License Kandallstown UD21133 Load 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ears **Physician** /Medical Due to (or as a consequence of) Examiner Scleroderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 1010 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠ Yes 2 □ No 24a. Was an autopsy performed Yes 2 ∏ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 📝 No 1 Inpatient 2 ER/Outpatient Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Pruneral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE. BALTIMORE State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 12:28 P.M May 01. William Henry Lueq /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) Stutzgard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Funeral Months Days Hours Min. 1X M 2 ☐ F Feb. 27, 1928 81 379-40-2276 Director Germany Usual Residence of Decedent 10d, Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exercises must be netfiled at 1 ∏Yes 2 No Director Phoenix Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21131 2 Club View Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No f Yes, Give Year or Dates: Specify Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Manager Mercedes Benz is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be facent of Health and Mental Unknown Unknown ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health au Important: If Item 27 is any injury or other trau once. 21131 Mrs. Therese Kolbe-Lueg (Wife) 2 Club View Lane Phoenix, Maryland Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 04ù Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem.Gardens Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility eaceful Alternatives Funeral&Cremation Ctr.,P.A. 21. Signature of Funeral Service Licensee 21093 2325 York Road Timonium, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis shock, or heart failt Immediate Cause (Fine) disease or condition resulting in death) used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. Usyonly one cause on each line **Physician** weck(/Medical Due to (or as a consequence of): Examiner Social results in the second s Due to (or as a consequence or): Examiner that the death certificate be executed and Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Vear ō 5 Other (specify) signed by the a 1 □ Yes 2 □ No Ö 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 100 certificate 1 □Yes 2 □No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405 Price Yes 2 □ No P 28d. Describe how injury occurred To the Hospital or Attending Pleasing 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation Stairs 1 ☐ Yes 2 MNo Fall down April 3 2009 2 Accident 6 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Club VIIW IGNE, Phoenix, MO 3 ☐ Suicide 286 determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) MAY 0 4 2009

Lucq, William

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 1 28, 2009 **Physician** John Edward Lusco 12:42 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F 80 Maryland 217-24-3171 April 4, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It of Madical Examiner must be notified at 1 XYes 2 No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 4704 Grindon Avenue 10f. Zip Code USA 21214 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 To Yes 2 □ No WIII If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 👿 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician/ Project Manager Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be John P. Lusco Ruth M. Toft ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum 4704 Grindon Avenue Baltimore Maryland 21214 Mary Lusco/ Wife Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/09 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck 5305 Härford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed's Hospital or Attending Physician: The 1 ☐ Yes 25. Was case referred examiner? funeral director, edical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of Injury 27. Manne eath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 Could not be determine 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintained as scaled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely (Check only one) within 2. 29b. Signature at and address of person who completed cause of death (Item 23a) (Type, Print)

State 'Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03413 State of Maryland / Department of Health and Mental Hygiene Charles Locklear Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 26, 2009 0653 hrs Medical Examiner Charles Locklear 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country Carolina Min Months Days Hours 05/03/1958 Director 1 X M 2 F 50 Yrs 217-68-1217 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No North items 23a or 28a-f show Shannon Robeson the Medical Examiner must be notified at once Carolina Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 28386 105 Vintage Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married Never Married American 2 X No Yes Indian 2 X No specify Yes If Yes, Give Year 3 Widowed Divorced 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic event, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Roofing Home **Improvement** 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne Chavis Douglas Locklear Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) North Carolina 28386 105 Vintage Drive Shannon. Anne Locklear - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/01/2009 Baltimore, Maryland Oaklawn Cemetery Donation 5 Other Specify 22. Name and Address of Facility ice Licensee Signature of Funeral Ser Dayid J_{Chester} Funeral Homes P.A. Maryland 21231 applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Part I. Enter the disease, 23a. Between Onset and Physician ailure. List only one caus on arch line Meldical Pneumonia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit certificate be executed 23a,2/,perME, G893 7/7/09 Physician/Medical X AMENDED UNPENDED ned by the attending physician detached for use as the burial -23d. Date of delivery Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 law requires that the death Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 4 V Unknown 1 Yes 2 No 3 þ Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed' has 1 🗸 Yes Yes 2 After this certificate 26.Place of Death (Check only one) DIVISION.
of Hospital or Attending Physician: 25. Was case referred to medica Be Other; 6 Other Hospital: 1 ✔ Inpatient 2 Nursing Home 5 DOA ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No Pendina the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be Suicide determined To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

ensur

istrar's Signature

and address of person who completed cause of death (Item 23a)

4

29b. Signature and title of certifier

31. Date filed (Month Pay

Pamela E. Southall, MD

29d. Date signed (Month, Day, Year)

April 29, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03420 State of Maryland / Department of Health and Mental Hygiene Dorothy Mather Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 28, 2009 1305 hrs Medical Examiner Dorothy Esther Mather 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** Good Samaritan Hospital Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Min Country) Maryland Director 1920 M 2 XF 88 Yrs 220-05-5281 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 X No or 28a-f show Fullerton Maryland Baltimore or items 23a or 28a-f sho must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4102 Taylor Avenue, Apt. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married 2 X No Yes other than "natural", or White Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Mirdical Examiner in Specify: If Yes, Give Year Yes 2 X No specify: 3 X Widowed Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12th. Grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Wiley Langkam Conrad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 903 C<u>ider Mill La</u>ne Be1 MDRonald Mather/Son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 X Burial 2 05/02/2009 Baltimore Parkwood Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Sign at re of Funeral Service Licenses 6415 Belair Road Baltimore MD 21206 Approximate Interval ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or Physician Between Onset and failure. List only one cause on each line. Death **Medical** a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown ned by the detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No 1 🗸 Yes certificate h ector, page ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 PER/Outpatient 3 this 1 V Yes ۵ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Apr 28, 2009 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Driver auto auto collision 1240 hrs Natural 1 Yes 2 ✔ No e Funeral Director: / Pending death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) Taylor Avenue and Oak Avenue, Baltimore, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D

Registrar

31. Date filed (Month, Day, Year)

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 29, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 5 2 15 AM the Mae Moore Z009 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore nes Hospital If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth Pay, 19935 Birthplace (State or Foreign Country) 7. Age Social Security Number Û 6. Sex **Funeral** Days Min. 1 □ M 2 🕱 F 216-20-6158 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 **V**es 2 □ No Raltimore Director 10g. Citizen of What Country? 23a or Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 'natural", or items 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Blac Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumation. Keeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 192. Informant's Name/Relationship (Type. Print) Green lawn Rd., Gwynn Oak, ion (Name of Date 20c. Location - Ci 2802 Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5.6.09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 23a. Part1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. au Immediate Cause (Final disease or condition resulting in death) **Physician** day mass ung /Medical Due to (or a a consequence of): Examiner effusion Leuval Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last acute Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. ular Physician/Medical Nellvosarco 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. ed by the a 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' this certificate 1 ☐Yes 2 No 1. Yes 2 □ No Division of Vital e Hospital or Attending Physician: 1 24 hours after death. e Funeral Director: After this certifical letely filled in by the funeral director, p. 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 DOA 2 ■ ER/Outpatient 3 ■ DOA ပ 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MO 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

144

Tao

caton Avenue MD Registrar's Signature

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:41 AM [muel 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Baltimor Maple Birthplace (State or Foreign County) If Under 2 7. Age (In yrs. last birthday) Months Days Min. Hours 246-20-513 Usual Residence of Decedent Yrs. 10d. Inside City Limits 10c. City, Town or Location 1 ☐Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □ No 1ac 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) grade 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type. Arint) Mite 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings 4 ☐ Donation 5 ☐ Other (Specify) augho c. Green e funeralson 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 eun nj Due to (or as a consequence of): ens Disbeter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a or

'natural', or

than "

is marked other or other traumatic event,

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked 1 any Injury or other traumatic ev

2 should be filed within and Mental Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

certificate be

the Medical Examiner must be notified at

Funeral Director

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Completed

Examiner burial-tran and attending physician the as use for signed by the aid been si cate has page 2 s certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 2 Certification:

Physician/Medical 2 Completed 25. Was case referred to medical examiner?

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐No

1 Yes 2 → No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier

052113

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

Phul ~ 21202 neito

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 0 4 2009

5 ☐ Pending investigation

6 ☐ Could not be

determined

R. LAND egistrar's Signature 32

SARUNDAY

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 30, 2009 2:15 p April Muffoletto Jacqueline /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Manchester Carroll Long View Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 88 March 26,1921 MD **Director** 216-24-4482 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, in a literation Examinar must be notified at 1 ☐ Yes 21 No Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 107 Glyndon Drive, Apt. A2 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify. ۵ 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Watkins Place Hostess 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Muffoletto traumatic Muffoletto Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traun 6235 Robin Hill Road, Baltimore, MD 21207 Tom Saia Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lorraine Park Cem. 5/7/09 Woodlawn, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician imes disease or condition /Medicai resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-trans a consequence of) Box 68760, Physician/Medical To the Hospital or Attending r.m. version 24 hours after death.

To the Funeral Director. After this certificate has been signed by the aftending plant the Funeral Director, After this certificate has been signed by the after the completely filled in by the funeral director, page 2 should be detached for use as I IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar nd address of person

mn

DHMH 17 Rev 1/2001

ORIGINAL

munchester, MD 21102

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:45 29, 2009 April McGinn, Sr. Francis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown 5009 Old Court Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2□ F 83 MD April 15,1926 Director 216-20-1365 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be exitted at 1 ☐ Yes 2 X No Director Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21133 Funeral 5009 Old Court Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1XiYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: ۾ 3 X Widowed 4 □ Divorced WWII White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Store Planning Hecht Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 Is marked off jury or other traumatic even Marie Veronica Uphoff Leo A. McGinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Taiper Court, Owings Mills, MD Daughter Marie V. McGinn If item : 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or 5/2/2009 Parkwood Cemetery Baltimore, MD 21. Signatule of Funeral Service Lice 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home Sle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician MINULES /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to for as a consequence of): physician and the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown brilla Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 0 4 2009

29b. Signature and title of certifier

Old Court Rd, Pikesville 32. Registrar's Sigrature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MILLER PAUL 10:30 AM 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs 8. Date of Birth 02/08/1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 93 215-12-8439 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 □ No MD BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7015 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Black, White, etc 1 X Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 🛣 No ARMY Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **LABORER** CITY GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JOSEPH** MILLER CAPLAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7013 PHEASANT CROSS DR., BALTIMORE, MD 21209 MORRIS ROSEN / BROTHER-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD HEBREW YOUNG MEN :05/01/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a la consequence f): normania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, the Medical Examiner must be retified at once.

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or

Baltimore, Maryland 21215-0036

attending physician and burial-trar the ģ cate has been signed page 2 should be del certificate this Director: After the

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner?

autopsy perform 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) to SDICE

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
	6	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac fy)	ctory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)
						e, and due to the cause(s) and manner as stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

29a. Cei

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Burton SMITH Avenue Surte

State Registrar

31. Date filed (Month, Day, Year)

and manner stated

within 24 hours aft

To the Funeral Di

completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTER OF MENTION AND PERETIMENT OF HEALTH AND Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year Maggaret Ann Ni 4a. Facility Name (If not institution, give street and number) **Physician** 07:3:AM APRIL 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMON &
If Under 1 Year | If Under 24 Hrs. AGNES HOSPITAL 8. Date of Birth (Month, Day, Year 10 14 19 9. Birthplace (State or Foreign Country) Social Security Number 5. Social Security Number 343.36 · 1092 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 ☐ M 2 🗗 F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State 28a-f show other traumatic event. The Medical Examiner must be notified at Baltimole 1 Pres 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò itеms 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) and 2 should be flealth and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Linnard 20c. Pocation - City or Town, State
Woodlawn item 27 i (daughter) permit. Pages 1 a
Department of He
Important: If item
any injury or othe
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Comoker 05.06.09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee GREENE FUNERAL SERVICED 23a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** URO 58.891 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of): Physician/Medical 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 □Yes 2 ☑No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Division 5 Pending investigation 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 900 77. SUCHANGGO BAITIMICKE CATION AVE 32. Registrar's State Registrar

1 - For State Registrar 1. Decedent's I

Be Completed by Funeral Director

2

Physician /Medical

Examiner

Funeral

Director

State Registrar		f Maryland / [•	rtificate of D			g. No. ?	0.09	11,191
Decedent's Name (First, Mic	idle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
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Facility Name (If not institut	tion, give street and nu	mber)		4b. City, Town, or I	Location of Deat	th	4c. Co	unty of Death	1
Sinai Hosp	sital of	Baltimor		Baltim		2:+4		0.51.11	(0)
Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Cot	nplace (State or Foreig
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al Residence of Decedent State 10b. Cour	nty	10c. City, Tow	n or Lo	cation					10d. Inside City Limits
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Marital Status	12, Was Dec	edent Ever in U.S.	13.	Was Decedent of His	spanic Origin? (Specify Yes or No-		Race - Amei	
1 ☐ Never Married 2 🙀 M	Armed Formation 1 □ Yes	2 📉 No	'	If Yes, specify Cubar	n, Mexican, Puei	no mican, etc.)		Black, White	, etc.
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(Specify only hig lementary/Secondary (0-12	hest grade completed) 2) College (1-4or 5+)	life. I	DO NOT use retired))				
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Father's Name (First, Midd						me (First, Middle, M.	aiden Sui		(TI1)
layton Nu	inn				Maggie				(Unknown)
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Frances Nunn	Wife	≥ 1.5	57 W	lilgate Ro	L	3/111-	MD	2111	7
						ngs Mills			
•	n 3 □ Bemoval from	State 20b. Place comete		osition (Name of matory or other place	e)	Date 2	0c. Locat	ion - City or	Town, State
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/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical

in the pa 1 ☐ Yes 9 ☐ Unk Part II. Other s 25. Was case examiner 1 ☐ Yes 27. Manner of 2 Accid 3 Suicid determined City or Town, State) building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number

Hosp:tal

29d. Date signed (Month, Day, Year)

RES -000

of Baltimore

Hasnik Arzumanyan Ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hasmik 31. Date filed (Month, Day, Year)

MAY U 4 2009

32. Registrar's Signature

parker

State

Registrar

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		ene g. No.	14133
	Physic /Med		1. Decedent's Name (First, Middle, Last) Edward A. O'Rourke	2. Date of Death Month May 1	Day Year	3. Time of Death 11:00AM
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital 5 Social Security Number 6 Sex 7 Ang (In yrs last birthday) If Under 1 Year If Under 24 Hrs.			h 20me ry hplace <i>(State or Foreign</i>
	Funera Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Day, May 6,	Year) Co	California
	th with the Maryland 23a or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 ☒ No
9	er dea items	Funeral	10500 Rockville Pike #1009 11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No 1 ☒ Yes 2 □ No 1 ☐ Yes 3 ☒ No Specify:			States rican Indian, e, etc.
r C	d Z IZ I 3-UU.S filed within 72 hours Hygiene. ther than "natural", int, the Modies Exe	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 UWII 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Jeweler	sing 1	6b. Kind of Business/	White Industry Own Store
	Maryland 212 nd 2 should be filed withi lith and Mental Hygiene. 27 is marked other than traumatic event, then	To Be C			aiden Surname) Hamilton	
30 A.M.	DallIMOre, Maryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours aft Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natura", or any hijury or other traumatic event, the Marical Expris		Katherine O'Rourke Wife 10500 Rockville Pike for the place of Disposition (Name of cemetery, crematory or other place) Montgomery Montgom	#1009, Ro Date 2 1ay 2009	ockville, Noc. Location - City or	Maryland 2085 Town, State Maryland
Me M	Physician /Medical Examiner		23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events.			Approximate Interval Between Onset and Death
11 8	box borlow, —— leath certificate be executed eatending physician and I for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No No No No No No No		23d. Date of de Month	livery Day Year
T	_ <u> </u>	Ď.	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	o the cause of death? robably 4 ∑ Unknown
Eduara	VII.dl necords, ician: The law requires t certificate has been signe ector, page 2 should be o	Be Completed	25. Was case referred to medical 26. Place of Deal	24a. Was an autopsy perform 1 Yes 2	rior to death? ☑No 1 □ Yes	utopsy findings available completion of cause of
ui	ding Phys h. After this	Certification: To E	examiner? 1	28d. Describe how	eet and Number or R	
ROU	Thospital 24 hours Funeral	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
Ojo	To the comple	Me	29b. Signature and title of certifier Alphabetrania M D-27 660	29	9d. Date signed (<i>Moni</i>	th, Day, Year)
	12)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/	

DHMH 17 Rev 1/2001

State Registrar Alpana Goswami 31. Date filed (Month, Day, Year)

Rockville Pike #100 Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Olalo oi ii	ar yraric	Cer	tificate of I	Death		leg. No.2	009	14196
	Dhysisis		1. Decedent's Name (First, Middle, La						2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Morgia J. Penn						April	29	2009	11:00 A M
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or Bethe	r Location of Death			unty of Death	
-			Maplewood Park 5. Social Security Number 6.		ge (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	 h	9. Birth	place (State or Foreign
	Funeral Director		219-48-3097	1□M 2 X F	90	Yrs.	Months Days	Hours Min.	June 17	, Year) 7, 191	8 Min	ntry) nesota
	pu ,		Usual Residence of Decedent		100 City	, Town or Lo	ention					10d. Inside City Limits
	arylar show	۲	10a. State 10b. County		1	,	cation					1 □Yes 2X No
	the M	ecto	Maryland Montgon	nery	Ве	thesda	10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural", or items than "natural".	Funeral Director	9707 Old Georg	etown Road	1		2081	4		Un	ited S	tates
	death	nera	11. Marital Status	12. Was Deceder	t Ever in U.S	3. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14.	Race - Ameri Black, White,	
õ	after or ite	y Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 X If Yes, Give			1 □Yes 2 X No	Specify:				nite
2-003b	hours tural",	ed by	3 X Widowed 4 □ Divorced	Year or Dates	:	16a Decer	dent's Usual Occup	nation	-	16b. Kind	of Business/Ir	
<u>.</u>	in 72	Completed	15. Decedent's E (Specify only highest g	rade completed)	(5.)	(Give	kind of work done DO NOT use retired	durina most of wor.	king			,
7 7		mo	Elementary/Secondary (0-12)	College (1-4o 5+	5+)	Нс	memaker				Own Ho	me
2	e filed al Hy d othe	Be	17. Father's Name (First, Middle, Las					18. Mother's Nan			rname)	
yland	Ment Ment arkec	၉	William Anders	on					a Mansur			
Mar	2 sho h and ris m raum		19a. Informant's Name/Relationship William H. Penni			1	ng Address <i>(Street</i> Upper La					
e,	1 and Healt em 27 ther 1		20a. Method of Disposition		20b. Pi		sition (Name of matory or other place		Date		tion - City or T	
Baitimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		e i		natory or other plac Memorial P.	****	y 4,	Roci	kville.	Maryland
	mit. F partme cortan Injur	İ	21. Signature of Funeral Service Lice	-	rari							y Chase, Inc.
ñ	permi Depa Impo any Ir		> 46m R. Barn	hart	M0154	6 7	557 Wiscons	sin Avenue,	Bethesda	, Mar	yland 2	20814
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Dy.	Physician		Immediate Cause (Final disease or condition	End Sta		ementia	1					Oliset and Death
	/Medical Examiner		resulting in death)		as a consequ							
	LXammoi	<u>-</u>	Sequentially list conditions,	b. Respira	atory as a consequ		re					
W	uted I Insit	Examiner	Sequentially list conditions, it is a cause. Enter Underlying Cause. (Disease or injury									
7	exectin and ial-tra	Еха	that initiated events cresulting in death) Last Due to (or as a consequence of):									
8/60,4	rtificate be executed ng physician and as the burial-transit	Medical		d								
B G	= 50 m		IF FEMALE:									
ŏ n	death cer le attendir ed for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Fetal	Ideath 3	Ectopic pregnand	су		23	 d. Date of deli Month 	very Day Year
	the de	Physician/I	1 □Yes 2 🖾 No 9 □ Unknown	4 ☐ Pregnan 9 ☐ Unknowi		leath 5L	Other (specify) _					
ت	w requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
Vital Records,	quires an sign ald be	d by	Seizures						10	Yes 2🛚	No 3□ Pr	obably 4 🗌 Unknown
ပ္က	law rec as bee 2 shor	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of
Ĭ	о <u>с</u> о	mo							perfo	rmed?	death?	2 □ No
<u> Ta</u>	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						ath (Check only o	one)		
<u></u>	Physic this co al dire	2	1 Yes 2 No				III OLI DON		Home 5 ☐ Resi			cify)
	ling I After funer	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending		njury D <i>ay, Year)</i>	28b. Time o Injury	Wo	iry at rk?]Yes 2 □ No	28d. Describe	now injury o	occurrea	
<u>s</u>	after death after death Director: d in by the	ficat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 280 Place of	Iniury - At ho	ome, farm, sti	reet, factory, office	169 5 160	28f. Location (Street and	Number or Ru	ıral Route Number,
Division	声	Certification:	4 ☐ Homicide determine	d building,	etc. (Specif	(y)	,		City or To	wn, State)		
	the Hospital of thin 24 hours a the Funeral D		29a. Certifier 1 X Certifying	Physician: To the be aminer: On the basi	st of my kno	wledge, deal	th occurred at the t	time, date and place	e, and due to the	cause(s) a	and manner as	s stated.
0	To the Hosp within 24 ho To the Fune completely f	Medical	one)	and manner					——————			
	Vith Vith	Σ	29b. Signature and title of certifier	10		0	29c. Licen				signed (Montl	
			Mulign	Ven	Mu	-jul		5791		Apr	il 30,	2009
			30. Name and address of person where 1yn Vemury,					lite 227	Silver	Sprin	ıg, Mar	land 20902
F	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Sig	iture	Mad .			- F 1.	3,)	
	Registr		31. Date filed (Month, Day, Year)	19 Senson	UB.	Mar						
_			10/12/2									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# I perPHYS G891 574/09 WS
State of Maryland Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Robert E. Payton Physician 2310 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore orthwest HUSP. HM Canter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 73 Yrs. 1 M 2 □ F **Director** Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Wedical Experient and the myllihed at Randallstown 1 ☐ Yes 2 No Balti mo Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21133 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify 2 BLOCK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "na any Injury or other traumatic event. It is Mental once. Elementary/Secondary (0-12) College (1-4or 5+) grade Hralust 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 una 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kar Callstown, no 2/133 Ave. NIC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State -1-09 Himore, NUS 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee CULP Approximate Interval Between Onset and Death 23a. Part 1. Ertler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INterstitia **Physician** 18 months IMDNOV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending ph for use as the IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. I ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 3 Probably 4 ☑ Unknown 1 □ Yes 2 □ No Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed? certificate iubetas 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ₺No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00065425 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 Randalls to UN, MD Kut 2 5401 Costf Old Mi) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AMonth Day Year LOCA 5: 15 A M teterson 28 4b. City, Town, or Location of Death 4c. County of Death Arlington West Nursing TRehab Ctr. Facility Name (If not institution, give street and number) Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-14-1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 238-40-9449 1□M 2**X**F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Baltimore 1MYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 USA nahurst 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Blac Specify: 3 Widowed 4 ☐ Divorced Kind of Business/Indus 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT useretired) Montruse College (1-4or 5+) Elementary/Secondary (0-12) Dervices Dupervisor Father's Name (First, Middle, Last) 18. Moth er's Name (First, Middle, Maiden Surname) ines quista narles Rural Route Number, City or Town, St. City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number Niece ndhurs 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, mo 21. Signature of Funeral Service License 23a. Part1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac arrythemios 20 MMHRS Due to (or as a consequence of) Atherosclevotic heart disease 5 40914 Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last heave foilure 2 415 Congestire Due to (or as a consequence of): 1540 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chanic menel Hailure Dicketes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No Demennia Chronie obsMcHire Lung Onemia 24a. Was an autopsy performed? (es 2 No Hyperlipedamia, . O stewarthrins disease 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

/Medical Examiner law requires that the death certificate be executed and burial physician the burial Box 68760. by the attending partached for use as P.0. signed i Division of Vital Records, peen has page 2 s certificate Hospital or Attending Physician: director, After th funeral within 24 hours after death.

To the Funeral Director: A To the Funeral Director: completely filled in by the f 2

Physician

Examiner

Funeral

Director

28a-f show

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items 23a

'natural", or

permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item 3.

Physician

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examinar must be notified at

Funeral Director

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Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

/Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lane contonsville morrices Maidenchoice SAI NO 32. Registrar's State Registrar

and manner stated

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

030494

29d. Date signed (Month, Day, Year)

4/28/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

averne Parham		State of Maryland / Department of Health and Mental Certificate of Death	2009 1419
Physicia		Registrar 1. Decedent's Name (First, Middles, ast)	2. Date of Death 3. Time of Death
ledical Examir		Laverne tarham	Month Day Year 0345 hrs
		4a. Facility Name (if not institution, give street and number) Maryland General Hospital 4b. City, Town, or Location of De	eath 4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	
Director		217-88-9310 1 M 2XF 46 Yrs. Months Days Hours	Min. 10 31 1962 Foreign Country) MD
		Usual Residence of Decedent	
ow any		10a. State 10b. County 10c. City, Town or Location Baltimore	10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once.	향	MD Baltimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
he Ma r or 28	Director	1645 N. Calhoun St., 129 21217	usA
death with the Maryland or items 23a or 28a-f sho must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14. Race - American Indian, Black,
r death	Funeral	1 Yes 2 No	Tlank.
hours after 'natural'',	۾	3 Widowed 4 Divorced If Yes, Give Year 1 Yes, 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	Specify: DIACAC I of work done 16b. Kind of Business/Industry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	
036 Arthin and and and and and and and and and an	dm	12th Nurse	Private Duty
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the M.di:a		17. Father's Name (First, Middle, Last)	lame (First, Middle, Maiden Surname)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Medical Examiner must be notified at once	To Be	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rural Route Number, City or Town, State, Zip Code)
MD id 2 sho lith and m 27 is aumati		20001 1001 10011 (11 (11 (11 (11 (11 (11	Rd., Balto., MD 21229
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
트레인트		4 Donation 5 Other Specify: 5 Samson west 5	5.11.09 [Owings Mills, MD]
Baltimo permit. Pag Department Important: injury or of		21. Signature of Euneral Service Licensee	Greene Funeral Services
Physician	\dashv	23a. Part I. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	iac or respiratory arrest, shock, or heart Approximate Interval
/Medical xaminer	- 27	failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of chronic drug al	buse Between Onset and
kallillei		or condition resulting in death) Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
_	Examiner	C. Due to (or as a consequence of):	4
		d	
0, e be executed ysician and burial - transi	edical	X _{JNPENDED} 23a,P11,27,permE, g891 5/12	709 TT
68760 certificate b ading physise as the bu		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	23d. Date of delivery equancy Month Day Year
Box 6876(ne death certificate the attending physele for use as the beath	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	egnancy world bay real
Box ne death c the atten	Phys	1 Yes 2 No 9 V Unknown g Unknown	23e. Did tobacco use contribute to the cause of death?
	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus; Hypertension	1 Yes 2 No 3 Probably 4 Unknown
rds, require been sig	Completed		24a. Was an 24b. Were autopsy findings available
e law re has b	du		autopsy prior to completion of cause of death? 1 Yes 2 ✓ No 1 Yes 2 No
of Vital Records, ig Physician: The law requirement the this certificate has been so neral director, page 2 should I		25. Was case referred to medical 26.Place of Death (Ch	
Vita nysicia this ce	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other; 4 N	lursing Home 5 Residence 6 Other:
n of ling Pl After funera	ü	27. Manner of Death 28a. Date of Injury (Morth, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division Isl or Attendir Is after death. Is Director: A	cati	2 Accident Investigation	28f. Location (Street and Number or Rural Route Number, City
Divi	ertification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, State)
교등등교	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the cause(s) and manner as stated.
Fo the Hos within 24 h Fo the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	
DAMES - S - S	ž	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		Culture O.C.M.E.	May 1, 2009
		 Name and address of person who completed cause of de th (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 	21201
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist		MAY 0 4 2009 Server B. Jacks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🖺 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Helen Annette Piccinini 610 AM APRIL 2,0009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Mary land 1 □ M 2 🛛 F 212-07-6870 87 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 √Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4714 Walther Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2√√No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaw Poniatowski Sophia Brukiewa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) August D. Piccinini, Sr./ Husband 4714 Walther Avenue Baltimore Maryland 21214 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 5/1/09 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTPLE SYSTEM ORGAN FAILURE. disease or condition resulting in death) Due to (or as a consequence of): ONGESTIVE BARS Due to (or as a consequence of): DRONAKY Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 Live birth 2 Fetal dead
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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r than "natural", or items 23a or 28a-f shov the Medical Examinant be retified at

72 hours after

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permit. Pages 1 and 2 st Department of Health an Important; If item 27 is r any injury or other traur

Maryland 21215-0036

Baltimore,

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of Vital Records,

Division

Esquentiary list occident, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 9 Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

31. Date file

29b. Signature and title of certifier

MD MD KY

32. Registrar's Sanature

and manner stated

29c. License number AT 2438946 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

UNION MEMORITE

BALTIMORE

Registrar

within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 0143 AM April 30 2009 ALAN J. RUDDLESDEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
APRIL 29,2009 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Days 1 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 21234 USA 35 HAPSBURG CT Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state 1 XNever Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 'natural", or 1 Yes 2 No WHITE Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GARY RUDDLESDEN CYNTHIA ROUDEBUSH ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35 HAPSBURG CT PARKVILLE, MD 21234 GARY RUDDLESDEN-FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL 5/5/09 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 21. Signature rvice Licensee 6224 EASTERN AVE BALTIMORE, MD 21224 23a Part 1. Enter the shock, or heart f edisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Una Nypoplasia Due u (or as a concernence of): **Physician** Una /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ue to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2+1No 3 Probably 1 Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 400 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No 1 🗌 Yes 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident by the 1 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30,2009 RES COC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satoute Monique 600 North Wolfe St. Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2่ังจื่9 Hilda Francina Soni May 2:01 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🕅 F 82 December 3, 1926 485-76-3546 Director India Usual Residence of Decedent death with the Maryland la or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 ☐ Yes 2 X No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6028 Berkshire Drive 20814 United States 23a 'natural'', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify. Specify: Asian-Indian 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be in the and Mental H Be Harold J. D'Cruz Dora F. D'Cruz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant; If item 27 Is Rajiv Pal Soni / Son 5948 Avon Drive, Bethesda, Maryland 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 4, 2009 Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01546 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiac Arrest (Asystole) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **Ileus** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Ischemic Colitis ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): requires that the death certificate be Physician/Medical Septic Shock IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 5 Other (specify) 9 Unknown О. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Records, Anemia, Failure to thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 🗆 Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division 1 X Natural 5 Pending investigation death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 13 29b. Sig and title of certif 29d. Date signed (Month, Day, Year) ature 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, Maryland 20814 M.D. Sima Nourani Zenuz, 32. Fegistrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

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State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

Sujatha Ramaseshan,

MAY 0 4 2009

31. Date filed (Month, Day, Year)

D0066416

9901 Medical Center Drive, Rockville, Maryland 20850

April 30, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Year Physician 1:07 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 900 Caton Avenue Hos If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, | 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) MD 217-16-177 Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Expression results and once. 1 Yes 2 No Funeral Director MD timore 10g. Citizen of What Country? 10e. Street and Number 21215 Hvenue 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eather's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City Balto. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE NEVMON **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for as mercasicalismos of To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director; After this certificate has been slaned by the attending hybridian and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 2 🗆 No Vital 26. Place of Death (Check only one) 25. Was case referred to medica Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES MARLOS CURTIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 **Physician** Patrick Smith 1645 28 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner Center Long Green Baltimore Baltimore city Genesis 8. Date of Birth (Month, Day) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1⊠M 2□ F Jan 8, Baltimore, 59 215-56-2442 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show injury or other traumatic event, the Medical Exercitive cust be notified at 1 ☐ Yes 2 ☑ No Director Randallstown Baltimore Co. MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or 3 USA 21133 3706 Wildor Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian, items 11 Marital Status Black, White, etc. 1 Never Married 2 Married ori Maryland 21215-0036 1 □Yes 2 🛛 No Specify. If Yes, Give Year or Dates: Specify: white à 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 than College (1-4or 5+) Rockland Industry Factory Work marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred Fallen Smith, Jr. Augustine J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 an 105 E. Cherry Hill Rd, Reisterstown, MD 21136] Ms. Misty Smith - daughter 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cemetery Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 11824 Reisterstown Rd 21. Signalure of Funeral Service Licensee Reisterstown, MD 21136 Eline Funeral Home J. Wayne Osterling 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart beliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septicemia 7 hours **Physician** /Medical Due to (or as a consequence of): Examiner Infection from wound and orine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 5years Multiple Scherosis law requires that the death certificate be executed End-Stage sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a □Yes 2□No Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No certificate Hospital or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 1. ertifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R154032 DShew CRNP 6095 marshafee Drive Elknoge, MD 21075 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SUSAN SCHERT CRUP egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 4:35P M Charlotte Virginia Sizemore 29, 2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1905 Penhall Road Dunda1k 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 245xF **Director** 11, 1938 Mary1and 70 212-36-4496 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I're I'redical Exeminations in cofficed at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Directo Maryland <u>Baltimore</u> Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 1905 Penhall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years <u>Housewife</u> <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Harris ဂ္ Howard W. Ritenour, Sr. 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 1905 Penhall Road 21222 Mr. Donald L. Sizemore, Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If It
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville V.A. Cem. 5/4/2009 Crownsville, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Survio Dundalk, Maryland 21222 7922 Wise Ave. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ajgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 In Nursing Home 5 Residence 6 In Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

within 24 hours after or To the Funeral Direct completely filled in by the Hospital

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chi-Shiang Chen, M.D. 301 St. Paul Place Suite 409 Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 MM9 Month IL 11:20F M Lewellyn R. Sebra 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Joseph Medical Towson Center Saint | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days | Hours | Min. | July 20, 1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Yrs. Mary Tand 1**X**☐ M 2☐ F 214-26-3236 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Maryland N/A Baltimore 1 XYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5023 E. Preston Street 21205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ If Yes, Give Year or Dates: 2□No Korea 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchandise Selector Paper Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewellvn R. Sebra Mary Smallwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10944 Baskerville Road Reisterstown Maryland 21136 Esther M. Cohen Stepdaughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/5/09 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) recharand Addinack Facilino 5305 Harford Road I Baltimore Maryland 21214 Mute Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): INFECTION TRACT URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Time to for as a nonsecuring offi-Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? END-STAGE RENAL DISEASE autopsy performed 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DØØ17695

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at angles.

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

ð

Be Completed

Medical Certification: To

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

the attending physician and hed for use as the burial-tran After this certificate has been signed by funeral director, page 2 should be detact

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

death. filled in by the within 24 hours after deatl To the Funeral Director; completely

Hospital

W State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7621 31. Date filed (Month, Day, Year)

6 ☐ Could not be

M. D. 32. Registrar Signatu MAY 0 4 2009

OSLER DRIVE

Helory M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health an 1 - State Registrar Certificate of Death	nd Menta		200	14208		
			1. Decedent's Name (First, Middle, Last)	2. Da	Heg ate of Death	, NoC U U .	3. Time of Death		
	Physicia /Medic		Dolores Theresa Sutherland	Apr	onth	7, 2009	- A4		
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	Funeral Director			Min. 11	onth, Day, \	930 M	Country) Iaryland		
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0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ir.e. Medical Engineer must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Married 2 Narried 3 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 No of the Status 1 N	n? (Specify Ye Puerto Rican,	es or No- , etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. White		
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EW COLE STAGNES 900 CATON AVE	BAL	LTIME	DRE MI	1 21229		
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EWCOLE STAGNES 900 CATON AVE 31. Date filed (Month, Day, Year) NAY 0 4 2009 Chrow A. January MAY 0 4 2009 Chrow A.						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 24 2009 Physician Taylor 4:23 Clara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day Jan 17 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min. Maryland 1 M 2 X F 60 Jan 220-56-3404 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra in a must be notified at once. 10b. County 10a. State 1X Yes 2 □ No Director Upper Marlboro Md Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20772 5605 Marwood Blvd # 414 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: Black ģ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Albert Johnson Clara Angeline Watson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type. Prist) Evelyn M. Cooke / Mother 5605 Marwood Blvd #414 Upper Marlbor Md Date 2009 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Wash Nat Cemetery Apr 30 Burial 2 Cremation 3 Removal from State Suitland 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility McLaughlin Funeral Home eral Service License 21. Signature 2019 MLK Jr Ave SE WAshington DC 20020 234. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to lor is a consequence of) **Examiner** rem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760∮ Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ worten 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐ Yes ector, 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral directors. 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

1328 Jonham arenve JE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Armen mo

DOUS 5120

Jack SID Washington DC

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OWN SEN d O 432 ert 2000 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TEA ISLAND Odenton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**/** M 2□ F Months Days Hours Min Usual Residence of Decedent 10d. Inside City Limit 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arunde 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 24cars Transpor driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Word L. Townsend, Sr rances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M. Townsend Odenton, MDZIII3 Wife 2014 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -09 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) Voughoc. Greene funeralsus 21. Signature of Funeral Service Licensee Randondallstorn, MDZ133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNSho Due to (or as a consequence of): Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
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Physician /Medical Examiner P.O. Box 68760, Records, Vital

Hospital or Attending Physician: The law requires that the death certificate be execute Division of

Completed Be Certification: To

Medical

Examine signed by the attending physician and the detached for use as the burial-transit Physician/Medical is certificate has been s director, page 2 should After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be unaffled at once.

Maryland 21215-0036

Baltimore,

25. Was case referred to medical examiner? 1 Yes

29a. Certifier

(Check only one)

1 Natural 2 ☐ Accident

Day Year)

04

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Deputy 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D06054

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 100 /Medical 4b City, Town, or Location of Death 4c. County of Death nd institution, give Examiner t/11001/6 imo 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min 1 M 2 F Months Davs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, It a Medical Examinat must be notified at 1 Yes 2 No MD imore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 2121 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 \mathcal{B} Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State -8-09 winas Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or hear fellure. List only one cause on each line. Immediate Cause (Final day Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician doe detached for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requir within 42 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deat 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 9

						Cei	tificate o	f Death	_	Reg. No.		
			1. Decedent's Name (First, Mid	dle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
Physician /Medica			Clarence G.	Wetter					27, 2009		9:00 A.M.	
);	Examin		4a. Facility Neme (If not instituti		umber)			4b. City, Town, o	or Location of Dea	th 4c. County	of Death	
			Villa Rosa Nur	sing Home				Mitchel	lville	Princ	e Geo	orge's
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday)	If Under 1 Yea			rth av. Yeer)	9. Birthp	lace (State or Foreign
	Director		071-03-7857	125M 2□ F	95	Yrs.	Working Day	3 110013 141	04/15/	1914	Ne	w York
g			Usual Residence of Decedent									
rylar	wo #		10a. State 10b. Coun	ty	100	c. City, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
e Ma		cto	Virginia Fair	fax	1	icLean						TEL TES ZENO
£	or 28)ire	10e. Street end Number				10f. Zip Code	•		10g. Citizen of V	Vhat Cour	try?
ž.	23a	a	1456 Highwood	Drive			2210			USA		
dea .	SE SE	Funeral Director	11. Marital Status	12. Was Dec Armed F	orces?	in U,S. 13.	Was Decedent of	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. Raci Blac	e - Americ k, White,	an Indian, etc.
of afte	or it	3	1 ☐ Never Married 2 ☐ Ma	arried 1 X Yes	2 No L	1/3/42-	1 □ Yes 2 X N			Specify	. vr.	
21215-0020 d within 72 hours after death with the Maryland	E 4	d by	3 X Widowed 4 □ Divorce	ed Year or I	Dates: 1	1/22/45					WIII	
5-6	hatn	Completed	15. Decede (Specify only high	ent's Education lest grede completed)	16a. Deced (Give	tent's Usual Occ kind of work dor	upation ne during most of ห red)	vorking	16b. Kind of Bu	usiness/Ind	dustry
121	ne.	du	Elementary/Secondary (0-12) College (1-4or 5+)							A A	. 3	
9d %	ygiel National	S	11			FTEC	tro-pla		Inna /Pina Middle	Automo		
in G	d off	Be	17. Fether's Name (First, Middle							e, Maiden Surnam	16)	
Maryland	Men arke	ဥ	William Wetter						sa Bialk			
lar 2 sh	and is m		19a. Informant's Name/Relation				•	et and Number or		-		Code)
and and	n 27 n 27 ner tu		Sharon Riotto,	Daughter				d Drive,		T		0
ore	f iter		20a. Method of Disposition 1 D Burial 2 DC Cremation	3 □Removal from	State 1	Ob. Place of Dispo cemetery crer Funeral	natory or other p	lace)	Date	20c. Location -	City or 10	own, State
Baltimore,	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f ahow important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		Donation 5 Other		Č	Chantilly	Inorces	01	5/1/09	Chantil.	ly, V	/irginia
alt mit	Departi importu any inj once.		21. Six nature of Punteral Service	e Licensee		22	2. Name and Add	ress of Facility	Old Town	Funeral	Choi	ces
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			23a. Part1. Enter the disease,	or complications that	caused the		er the mode of d	ying, such es card	liac or respiratory	errest,	-	Approximete Interval Between
Ph	nysician		shock, or heart failure. Li	st only one cause on	each line.						[Onset and Death
	Medical		Immediate Cause (Final	Can	tuia C	anaan					Į }	Years
E	xaminer		disease or condition resulting in death)	a. Gas		to (or as a consec	allence of):	· · · · · · · · · · · · · · · · · · ·			1	r cur s
		ē		Ad		Alzheim					1	Years
Wag	nding physician and use as the burial-transit	n/Medical Examiner	Coguestially list conditions	b		to (or as a consec	1					
ox 68760, centificate be execu	n an ial-tr	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury chat initiated events Cause Consequence of): Due to (or as a consequence of):									
760 ebe	/sicia e bu	ca	Cause (Disease or injury that initiated events	c	Due	to (or as a conseq	uence of):					
68760 , tificate be exe	g phy as th	<u>g</u>	resulting in death) Last				,				Ì	
		2		d								
de at	d for	Physicia	Part II. Other significent condit	tions contributing to	death hut no	t resulting in the u	nderlying cause	given in Part I	23b. Die	i tobecco use co	ntribute t	the cause of deeth?
P.O.	by the	hys			30000	t rooming in the o		3		Yee 2 No	3□ Pro	
that	ned t		Parkinsons	Disease					_ '-			
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Vit	recto	Be	25. Was case referred to medic examiner?	Hoopital		-5		Othor:	Death (Check only		(C	E.1
of Vita Physician:	this di	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Menner of Death	28a. Date		2 ☐ ER/Outpatier 28b. Time o	it 3LI DOA	4 34 Nursing	-	sidence 6 □Oth e how injury occur		y)
no gill g	After fune	ē	1 Natural 5 □ Pend	/8.4n	nth, Day Yea	ar) Injury	V	vork? □ Yes 2 □ No				
Vision	death tor: / the	icat	3 ☐ Suicide 6 ☐ Coul	d not be	e of Injury -	At home, farm, str			28f. Location	(Street end Numb	er or Run	al Route Number.
Division of Vital Records, or Attending Physician: The law requires the	within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	Medical Certification:	4 ☐ Homicide deter	mined 200. Flac	ding, etc. (S)	pecify)	eet, lactory, onto	,0	City or T	own, Stete)		
pitai _	erai l	ŏ	29a. Certifier 1 Certify	ring Physician: To th	a bast of my	r knowledge death	a conversed at the	time, date and pla	ace, and due to th	e ceuse(s) and m	anner as s	stated
Me Hospitai	Fune Fune	lica	(Check only one)	al Examiner: On the	basis of exa nner stated.	mination and/or in	vestigation, in m	y opinion, death of	ccurred et the time	e, date and place,	and due t	o the cause(s)
W g	thin the mple	Me	29b. Signature and title of certif		iller stated.		29c. Lice	ense number		29d. Date signe	d (Month,	Day, Year)
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			rapu	SO C	VIO	111	4	201	00	110		/
			30. Name end address of perso						1 300	20715		
			Rakesh Arora,				ane Sui	te 222 Bo	owie, MD	20/15		
, ,	Sta		31. Date filed (Month, Day, Yea		Registrar's S							
	Registr		MAY 042	009 Sens	-	1. back						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 2. Dete of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ne /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Bati If Under 24 Hrs. more Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) If Under 1 Year 9. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 1 □ M 2 1 F 248-48arolina Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 □ No Be Completed by Funeral Director more more 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Year or Dates 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) ဥ 19en e Idaughter 19a. Informarit's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 120 20b. Place of Disposition (Name of cemetery, cremetory or other place Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12009 Memoria 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Filmeral Service Licensee 22. Name and Address of Facility Joseph 2222 Home W. North Ave, Balto, Md 23a. Part1. Enter the disease, or complications that caus-of the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21216 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last 23h Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No After this certificate Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 28b. Time of Injur 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗆 Homicide within 24 hours e To the Funeral C 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier D3/322 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 116 MADENCHOICE CN, BALTO MD 21228 GARGAN 31. Dete filed (Mor 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#18perFH, G892, 6/4/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** harlotte Aori Ab. City, Town, or Eccation of Death 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 M & F Director 220-36-4391 28 69 0140 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Director or other traumatic event, the Medical Examiner must be notified MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code tems 23a or 3759 Columbus Drive 21215 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2x No Specify: Specify: Black þ 3 Widowed 4 X Divorced Year or Dates "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs+ 12th grade Social Worker State of Maryland marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manley Health and Mental Roger W. Jones Sr. Juanita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.e</u> Vivian Brown-Sister 3420 Milford Mill Road, Baltimore, Md 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or oti
once. tx Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 - Other (Specify) 5/5/09 Woodlawn, Md Woodlawn 22. Name and Address of Facility March F/H West 21 S of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the disease, or complications that can shirck, or heart lature. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Securabily list on littors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tyes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 Natural 1 Yes 2 No Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number Medica esicle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IOCA 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 4 2009 Registrar back

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3 Harrison Worrell Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner dale ware tal Cente tranklin 9. Birthplace (State or Foreign If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours **№** M 2□ F Maryland 82 27,1926 220-18-6214 Oct. Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, fire the district items and the indifficult at the indifficult in the field of the traumatic event, fire the district in an institut or other traumatic event, fire the district in an institut or other traumatic event, fire the district in an institut or other traumatic event, fire the district in a fire traumatic event. 1 ☐ Yes 2x No Director Essex Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21221 411 Riverside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 📉 No Specify ģ White 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Local 557 Elementary/Secondary (0-12) College (1-4or 5+) Trucking Industry Truck Driver 5 Years 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Margaret Sealover Harrison Worrell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 304 Kendrick Drive Aberdeen, Maryland Ms. Darlene Floyd (Daughter) 3altimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/30/2009 Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** n eu monia disease or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical cute the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy nerformed' certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ⊟ Yes 2 🛂 📈 б 1 ⊡ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2009 10:50 Williams April 30, <u>Joan</u> Hoskins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3–18–1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2**X**XF 169-32-4902 Director 68 <u>Pennsylvania</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2**X** No Directo Baltimore Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21234 U.S.A. Funeral 15 Graveswood Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify. δ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President, Human Resourses Health Care 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be ည Ryan Richard Hoskins Joan 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18940 <u>Brian Bark</u> 24 Delaney Drive Newtown, Pennsylvania Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-6-2009 <u>Newtown, Pennsylvania</u> <u>Newtown Cemetery</u> 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland مى 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Immediate Cause (Final y mon ND **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, taux, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? his certificate has I director, page 2 s periormed? 1 ☐ Yes 2 🔏 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No illed in by the f 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Funeral Completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)

2009

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mpleted cause of death (Item 23a) (Type, Print)

		For State Registrar			Certificate of L		F	Reg. No. 200	9 14217
Physicia	an	1. Decedent's Name (First, Middle					2. Date of Dea Month	Day Yea	
/Medic	al	John Edwin 4a. Facility Name (If not institution		·	4b. City, Town, or	Location of Death	April	17 200 4c. County of De	
Examin	er	Friends Nurs				Spring			gomery
uneral irector		5. Social Security Number 227 – 14 – 4723	6. Sex 1 ★ M 2 ☐ F	(In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov. 1	v, Year)	Birthplace <i>(State or Foreign Country)</i> Virginia
*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
f sho led at	or		oward		dbine				1 ☐ Yes 2 No
r 28a- notif	irec	10e. Street and Number	wara		10f. Zip Code			10g. Citizen of What	Country?
23a o ist be	al D	16470 Ed Warfi	eld Road			21797		United	States
tems er mu	Funeral Director	11. Marital Status	12. Was Decedent E		13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	. 14. Race - A Black, W	merican Indian, hite, etc.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	by	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
"natı	Completed	15. Decedent (Specify only highes	st grade completed)		Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired)	ation <i>furing most of worl</i> ')	king	16b. Kind of Busine	ss/Industry
than the M	omp	Elementary/Secondary (0-12)	College (1-4or 5+	•)	Farmer	,		Agricu]	Lture
other vent,	Be C	17. Father's Name (First, Middle,	Last)				_	Maiden Surname)	
arked atic e	To E	Travis C.	Byrne			Annie	e G.	Ellison	
is m		19a. Informant's Name/Relations! Kathy L. Allred			Mailing Address (Street a				
em 27 ther t		20a. Method of Disposition	1-MIIIS/Daugii				Date Date	20c. Location - City	
t: If its y or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Disposition (Name of ry, crematory or other place		21/09	Rockvil	
ortan Injur		21. Signature of Funeral Service		Parki	awn Cemetery 22. Name and Addres	s of Facility			10, 110.
any		Nonw.	Barner		Muriel I	H. Barber Box 5038	r Funera , Layton	sville, M	d. 20882
<i>Ş</i> .		23a. Part1. Enter the disease, or shock, or heart ailure. List	complications that caused to	the death. Do r					Approximate Interval Between
sician		Immediate Cause (Final disease or condition	a Acut	-	PIRMOR	1	MURC	c.	Onset and Death
ledical aminer		resulting in death)		consequence	,		n.		Mehos
	er	Sequentially list conditions, if any, leading to immediate	b. LARON Due to (or as a	consequence	STRUCTIU	CLUM	6 DIS	CAZC	YEARS
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ding p	-	IF FEMALE:	23c. If yes, outcome p	of pregnancy				23d. Date of	delivery
atter d for u	Physician/⊪	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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igned be de	by F	Part II. Other significant condition	_	t not resulting in	the underlying cause give	en in Part I.		`	e to the cause of death?
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has b	Completed	WITHREOSCL	600515 LEG	514EK	ST AMECACH	is Nice	auto	osy prior	autopsy findings available to completion of cause of h?
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s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Ou	tpatient 3 DOA Othe	26. Place of Dea er: 4 Mursing H		dence 6 □Other (5	Specify)
ter thi		27. Manner of Death 12 Natural 5 □ Pendin	28a. Date of Injun (Month, Day		Fime of 28c. Injury	y at	T .	how injury occurred	
or: Al	atic	2 Accident investig	gation		M 1 🗆	Yes 2 □ No			
Direct in by	Certification:	4 ☐ Homicide determ			rm, street, factory, office		28f. Location (3 City or Tox		r Rural Route Number,
neral filled		29a. Certifier FS Certifyln	ig Physician: To the best o	f my knowledge	e, death occurred at the tir	me, date and place	and due to the	cause(s) and manne	r as stated.
To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basis of and manner stat	examination an	d/or investigation, in my o	pinion, death occu	urred at the time,	date and place, and	due to the cause(s)
To the	Ň	29b. Signature and title of certifie	000		29c. License	e number	-	29d. Date signed (M	onth, Day, Year)
		3 Lept	Mana	THE		523012		4/12/0	0 7
1	-	30. Name and address of person	who completed cause of de	alh (Item 23a) ((Type, Print)	Ode i D	. 7	JER SPRIT	Mag 41 12
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	SRIGES CH	Auch K	SAD JIL	ver oficir	- 500 D
Registr		APR 2 (2009 Seneu	N. B.	parke				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death A Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day th 2009 Ballou **Physician** Aldene 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner County General Hospital Howard Columbia Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yo June 14, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year! Hours 1 □ M 2 🕱 F Months Days 1924 Texas 84 Director 465 48 1478 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21075 8109 Sunrise Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School System Professional Secretary 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Clarence C. Donohoe Jessie Ella Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8109 Sunrise Lane Elkridge, MD 21075 Elladean Brigham/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 4-24-2009 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Uns 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Anemia Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria rypo teusion Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4 Pregnant at time of death 5 ☐ Other (specify) ned by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 □Yes 2 □No 1 ☐Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation n 24 hours after death.

Be Funeral Director: A pletely filled in by the fu 1 □Yes 2 □No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

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To the within 2

State Registrar 29b. Signature and title of certifier

Bell Lane clarksulle MD 21029 lignal

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

050870

29d. Date signed (Month, Day, Year)

April 19th 2009

	4	For State	partment of Health and N ertificate of Death		g. No.	
		Registrar Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
Physicia	_	Margaret Frances Burkholder		April	24, 2009	9:50 PM
/Medica		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Examine	er	Kline Hospice House	Mount Airy		Frederick	colace (State or Foreig
Funeral	Ę	Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Hint	8. Date of Birth (Month, Day,	Year) 25 West	ntry)
Director		219–16–2377	3.	Abrir 1,	1929 Wes	st Virgini
ס		Usual Residence of Decedent	r Location			10d. Inside City Limit
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if th	Director	10e. Street and Number	21702		United Sta	ates
ath w	Ia I	1421 Taney Avenue, Apt. 317	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	ican Indian,
nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, it is located by the resolution of the traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 11. Was Decedent 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 15 in 1	If Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2 No Specify:	o Hican, etc.)	Specify: Wh:	
ural"	D D	. 100 [ecedent's Usual Occupation		16b. Kind of Business/I	ndustry
	Completed	(Specify only highest grade completed)	Give kind of work done during most of wor ife. DO NOT use retired)	Killig		
within jiene. r than	шď	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home	
Hygi Hygi ther		17. Father's Name (First, Middle, Last)		me (First, Middle, I		
d be d antal sed o sed o) Be	Pohart Martin		beth Hill		
hould id Me mark matie	ဥ	19h	Mailing Address (Street and Number or R	ural Route Numbe	r, City or Town, State, 2	Zip Code)
d 2 s ith ar ith ar 27 is 17 is		Doris K. Twentey / Daughter 521	5-F Wigville Road,		e, Maryland	Z1700
1 an Hea tem 2		20a Method of Disposition 20b. Place of	Disposition (Name of crematory or other place) Apr	il 28. l	20c. Location - City or	
ages ant of t: If i		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Oli	vet Cemetery	2009	Frederick,	
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, Ite Ingone.		21. Signature of Funeral Service Licensee MO1473	Keeney and Basfor 106 E. Church Str	d PA Fune eet, Fred	eral Home derick, Mar	yland 217
Physician /Medical Examiner	iner	resulting in death) Due to (or as a consequence of the to (or	, metastalic	19000	ANCINOMA	Mont
ate be executed hysician and he burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Hunder tender to Due to (or as a consequence of Coron Ary	stery di	sense		415
ath certific attending p for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify)		23d. Date of d Month tobacco use contribute	Day Yea
that ned b deta			n the underlying cause given in Part I.			Probably 4 🗆 Unk
uires n sign	d b	Hyperlipidemia		- "		
he law requires that the de e has been signed by the age 2 should be detached	Completed by			24a. Was auto perfo 1 ☐ Yes		
iclan: The certificate ector, pag		25. Was case referred to medical		Death (Check only		
Physician: r this certificanal director, p	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O			sidence 6 Other (Si	pecify) HOSDIC
ling Physiclan: The Individual of After this certificate humanal director, page	on: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	e how injury occurred	
at at	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e, Place of Injury - At home, for building, etc. (Specify)		28f. Location City or To	(Street and Number or own, State)	Rural Route Numbe
Hospital	edical Ce		e, death occurred at the time, date and p nd/or investigation, in my opinion, death of	lace, and due to the		
To the h within 2. To the f	No.	29b. Signature and the observifier Reilly	up 29c. License number D547	49	April 2 everick,	7 200 9
6)	30. Name and address of person who completed cause of deal (Item 23a AIEI KEILLY, MD 86 TOIL 31. Date filed (Month Day Year) 32. Registrar's Sanature	House Auc, S	-1 FRE	everick,	Md ZIT

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 6 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Connell Thomas Chaney April 22, 2009 7:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Year)
April 7, 1916 Maryland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1**҈X**M 2□F Yrs. 93 Director 214-07-5577 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar rount by notified at 1 ☐ Yes 2 🔀 No Director MD Garrett Grantsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v. Depc riment of Health and Menial Hygiene. Important: If Item 27 is marked other then "netural", or Items 23e any nigury or other traumatic event, the Medical Examinar resembles. 299 Hemlock Dr. Funeral 21536 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩2 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White þ 3 Widowed 4 □ Oivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Clergyman Church of the Brethren 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter Clay Chaney Alice Whiteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Lee Folk/Daughter 281 Hemlock Dr., Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Springs Cemetery April 25, 2009 Springs, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diarrhe **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the ettending physicien and detached for use as the burial transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical bro Vasc IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ۵ certificate has been signi rector, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 ☐ Yes To the Hospitel or Attending Physician: Be (After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturaf 5 Pending within 24 hours after death.
To the Funeral Director: A
completely filled in by tha fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ducals 0058655 heil

State Registrar

31. Date filed (Month, Day, Year)
APR 2 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sabahat Nawab, 891 Dorsey Hotel Rd., Grantsville, MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 17, Day 2009 Year **Physician** 12:45 AM Ariel E. Sherier Crist /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Rockville Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | May 12,1910 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Wash., 1 □ M 2 🕅 F Yrs D.C. 98 577-72-1622 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Va. Fairfax Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4207 Marble Lane 22033 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√☐No Specify. White þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nell Vaughn Mark Anthony Sherier ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Marble Lane, Fairfax, Va. 22033 Thomas R. Crist/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition APrilate 20. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 Donation 5 DOther (Specify) St. James Cemetery Falls Church, Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of) Hypertensive Heart Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner Coronary Artery Disease Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☑ Yes 2 ☐ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2\(\sum \text{No}\) 1 □ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1∐ Yes 2∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Box 68760, P.O. Division of Vital Records, after death filled in by within 24 hours a

Funeral

Director

items 23a or 28a-f show

or other traumatic event, the Medical Examiner must be notified at

purmit. Pages 1 and 2 should be filed within 72 hours after c Dapartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event. The Mental Hygies

Physician

/Medical

Examiner

State Registrar DHMH 17 Rev 1/2001

2

Medical

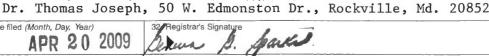
(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 20

Showin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Joseph

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0047330

29d. Date signed (Month, Day, Year)

April 17, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

2009

Montgomery

14. Race - American Indian, Black, White, etc.

White

Specify:

Education

4:50pm M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Pennsylvania

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Rosemarie L. Cardinale April 18, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Date of Birth (Month, Day, Year, Funeral Days Hours 1 □ M 2**X** F Yrs. 1935 Director Jan. 6, 086-26-4979 74 Usual Residence of Decedent 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D partment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Modicil Expuritor must be rediffed at ore. "natural", or items 23a or 28a-f show Directo Maryland | Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20874 20211 Laurel Hill Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔀 No ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teachers Aide 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Catherine Rogers ဂ္ Louis Pagano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20211 Laurel Hill Way, Germantown, MD 20874 Kathaleen Vita (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/22/09 21. Signature of Funeral Service License of 23a Part 1. Enter the disection of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** neh-vol disease or condition resulting in death) /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 1 ☐ Yes 2 🚾 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Completed 24a. Was an 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Dea 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No neral Director: P 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 👺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 29b. Signature and title of certifier 29c. License number

Silver Spring, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 32 Registrar's Signature **ORIGINAL**

State Registrar

William R. Dooley, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 10:00 April Sonji Monique Campbell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HCR ManorCare Nursing Home Prince George's Largo 8. Date of Birth (Month, Day, Year) 7/9/1965 If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 1 F 214-04-8103 43 Yrs **Director** Washington, DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at 1 X Yes 2 No Directo N.C. Wayne Goldsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Sumervale Lane 27530 USA Be Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Hecht Co. other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Campbell Christine Sanders ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) D partment of Health ar Important: if item 27 is any injury or other trau 100 Somervale Lane, Goldsboro, NC Christine Campbell - Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/20/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fort Lincoln Funeral Home 20722 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanced Multiple Sclerosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2X No 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 🔀 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No

P.0. Division of Vital Records, the funeral filled in by Funeral

> (3

Registrar

6 ☐ Could not be

MD

2 Accident

4 🗌 Homicide

3 Suicide

29a. Certifier

29b. Signature,

eted cause of death (Item

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 1) 51520 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

04-15-2009

09-03040 Cody Lee Coulbourne Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of Fillitin Die	ZOIC III GOILDIO II	 	
State of Maryland /			

2009 14224

		For State		Certi	ificate of	Death			F	Reg. No.			
Physician/		Decedent's Name (First, Middle,Last) Cody Lee Coulbourne 2. Date of Death Month Day April 16, 2009 3. Time of Death Month Day April 16, 2009											
∃ Examiner	ſ	Cody Lee Cou	ılbourne						April 16,	2009			0800 firs
	4	a. Facility Name (if not institution, g	ive street and number)		4	b. City, Town		of Death		1	. County of		
		11531 Riverton Wharf Ro	oad Nanitcoke Riv	/er		Mardela					Vicomico		
Funeral	5	. Social Security Number 6.	Sex 7. Age	e (In yrs. las	t birthday)	If Under 1		der 24Hrs.	8. Date of B	lirth(MM/	DD/YYYY)	Foreign	ace (State or
Director		221-70-1935	X м 2 F	23	Yrs.	Months	Days Hou	ITS IVIIII.	Jan.	24,	1986	Countr	y) DE
	t	Isual Residence of Decedent										1.0	The Charles
âu â	1	0a. State 10b. County		10c. City, T	own or Location	on							d. Inside City Limits
thow item	-	DE Sus:	sex	De1	mar							1	X Yes 2 No
ne Maryland or 28a-f show any fied at once.	<u>;</u>	0e. Street and Number				10f. Zip Cod	de			10g. Citi	zen of Wha	t Country	?
the Maryland a or 28a-f sh iffied at once	51	10178 Jackson	Street			1994	0				U.S.A	١.	
s 23a e not		Marital Status	12. Was Decedent		5. 13. Wa	s Decedent o	f Hispanic O	rigin? (Spe	ecify Yes or N	10-	14. Race - White,		Indian, Black,
or items 23	4	1 X Never Married 2 Marri	ed Armed Forces?	X No	If Ye	es, specify Co	uban, Mexica	an, Puerto i	Rican, etc.)		wille,	eic.	
fter d F, or F		3 Widowed 4 Divorc	ed If Yes, Give Year		-	Yes 2 X					Specify:	wh	ite
nurs after attural" amine		15. Decedent's Education (Specify		npleted)	16a. Deceden	t's Usual Occost of working	cupation (Giv	e kind of w	ork done	16b.	Kind of Bus	iness/Indi	ustry
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	e le	Elementary/Secondary (0-12)	College (1-4 or	5+)) use rem	CG)		-		
036 ithin r r tha fedic	림	11			Cre	w Fore						rvice	e Company
5-0 led w othe Oche		7. Father's Name (First, Middle, La	st)						(First, Middle				
21215-0036 July be filed within 7 Mental Hygiene. nuarked other than c event, the Medica		Unknown				Address (Pam	ela L	ynn Co	ulbo	ourne	State 7	in Code)
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	- □	19a. Informant's Name/Relationship										, State, Z	ip Code)
MD id 2 sho ilth and m 27 is aumati	L	Helen H. Jacks	<u>on (grandmo</u>	ther)	Place of Dispos	Box 3	9 De.	lmar,	DE I	9940	Location -	City or To	own, State
S l ar	1	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St	ate c	rematory or otl	her place)						-	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Tant: If iten 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		4 Donation 5 Other Spec	ify:	Cre	matory	of De	1marva	a 4-2	0-2009	D	elmar	, De	laware
Baltimore, permit Pages I at Department of Her Important: If ite injury or other tr	T	21. Signature of Funeral Service Lie	censee		22. 1	Name and Ad	dress of Fac	ility 1 Hom	ie.				
E.F.C.E	Ì	any Shorts	lewell		ĭ	hort I	rove	Stree	t Del	mar	, DE_	1994	O Approximate Interval
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or	mplications that caused each line.	the death.	Do not enter t	he mode of d	lying, such a	is cardiac o	r respiratory	arrest, sr	lock, or nea	iπ	Between Onset and
Medical .xaminer	1	Immediate Cause (Final disease	a. Drowning										Death
Adminer		or condition resulting in death)	Due to (or as a cons	equence of	f):								
<u>.</u>	ا ي	Sequentially list conditions,	b. Due to (or as a cons	equence of	F)+								
	ا≩	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of									
- Z	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of	f):				-				
			d										
760, icate be executed the burial and the burial are trans	sician/Medical	UNPENDED	AMENDED										
760, ficate be exg physician the burial	ĕŀ	IF FEMALE:	23c. If yes, outco	me of pregi	nancy					2	3d. Date of	delivery Da	v Year
687 ertific ding e as t	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	at time of de	nath.	etal death		opic pregna	ancy		Month	De	iy real
Box 68's death certiff the attending of for use as	Sic	1 Yes 2 No 9 Unkn		it time or do	ath 5 0	ther (Specif)	"			- 1			
that the de detached f		Part II. Other significant conditio		th but not re	esulting in the	underlying ca	ause given it	n Part I.	23e. Di	id tobacc	o use contr	ibute to th	ne cause of death?
P.O.	≦								. 1	Yes 2	✓ No 3	Proba	ably 4 Unknown
duired quired uld be uld be	Completed								24a. W		24b. \	Were auto	opsy findings available
Records, The law require fificate has been si y page 2 should to	휣								pe	utopsy erformed	?	death?	mpletion of cause of
Rec The l	팃									es 2	No 1	✓ Yes	2 No
tal Rection: The certificate ector, page	8	25. Was case referred to medical examiner?	11				.Place of De					4.00	
of Vital ng Physician After this certi uneral director	P.	1 ✔ Yes 2 No		ient 2	ER/Outpatier				ng Home 5				Scene
of Vital Recing Physician: The After this certificate funeral director, page		27. Manner of Death	28a. Date of Ir (Month, Day FOUND:	ijury ,Year)	28b. Time of FOUND:	′′′	c. Injury at V		Subject f	ell fron	injury occur n boat in	to river	
C # 1917	읉	1 Natural 5 Pendii 2 ✓ Accident Investi	Apr 16, 200	9	0800 hrs		1Yes 2						- D- to Number City
tenk eath for:	ا ق	3 Suicide 6 Could	not be 28e. Place of	Injury - At h	ome, farm, str	eet, factory, o	office buildin	g, etc.	or Tou	in State	\		al Route Number, City
Visior or Attend fler death Director: in by the	= 1	determ	(0)0000										la Springs, MD
Division pital or Attendio ours after death eral Director: filled in by the fi	ert.	4 Homicide		my knowled	ige, death occi	urred at the ti	me, date an	d place, an	d due to the	cause(s)	and manne	er as state	d. cause(s)
Division o Hospital or Attending 24 hours after death Funeral Director: Afte		29a. Certifier	sician: To the best of		and/or investig	ation, in my o	pinion, deal	iii occurred	at the time, C	acc and	piace, and		
Division of the Hospital or Attent of the Hospital or Attent of the Funeral Director: ompletely filled in by the		29a. Certifier 1 Certifying Phyone) 2 Medical Exam	/sician: To the best of liner: On the basis of example and manner state	amination a	and/or mivestig								
Division To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the	Medical Certif	29a. Certifier	iner:On the basis of ex	amination a	and/or investig	29c.	License nun	nber		29	d. Date sign	ned (Mor	th, Day, Year)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	iner:On the basis of example and manner state	kamination a	and/or investig	29c.		nber		29		ned (Mor	
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam 29b. Signature and title of certifier	iner:On the basis of exand manner state	d	m 23a)	29c.	O.C.M.E.	nber		29	d. Date sign	ned (Mor	
To the Hospital or Attent within 24 hours after death within 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam 29b. Signature and title of certifier 30. Name and address of person of	vho completed cause o	d. f death (Iten	n 23a) 111 Per	29c.	O.C.M.E.	nber		29	d. Date sign	ned (Mor	

Division or Vital Records, P.O. Box 68760. within 24 hours a

> 5 State Registra

(Check only one)

29b. Signature and title of certified

ANGELO 602 S. ATWOOD Rd BEL ASR # 205, 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 04 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1)0056607

29d. Date signed (Month, Day, Year)
April 27th, 2009

14226

			1 - State Registrar	State of Mary		rtificate of		, ,	eg. No.		7 4 2 2 0
	hysici		1. Decedent's Name (First, Middle, Last,) Helen Clark Du	ckworth			2. Date of Dear Month Apri	th I 2 ⁰ , 2009	Year	3. Time of Death 10:45 AM
	/Medic Examir	2.	4a. Facility Name (If not institution, give	street and number) Village Nursing I	Home	4b. City, Town, o	r Location of Death Frostb		4c. County		gany
	neral ector		5. Social Security Number 6. Sec. 215-82-3726	x 7. Age (In 85	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September	Year) 15, 1923	9. Birthpl Coup	lace (State or Foreign Maryland
faryland	ed at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Alleg		. City, Town or Lo	ocation	Frostburg			11	0d. Inside City Limits 1 ☐ Yes 2 No
with the	3a or 28a-	I Direct	10e. Street and Number	Ridge Lane S.W		10f, Zip Code	21532	1	0g, Citizen of	What Coun	ntry?
aryland 21215-0036 should be filed with the Maryland after death with the Maryland nd Mental Hygiene.	d other than "natural", or feme 23s or 28s-1 show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - America ck, White, e	
Maryland 21215-0036 td 2 should be filed within 72 hours af tth and Menial Hygiene.	an "natu Madical	npletec	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	king	16b. Kind of B	usiness/fnc	lustry
filled wi	marked other than imatic event, the M	d)	12 17. Father's Name (First, Middle, Last)	0		Но	memaker	e (First, Middle, I	Maiden Surnan	Hom	ie
Van Mental	arked c	To Be		Harry Clark				Gert	rude Gree	n	
, Mar and 2 sho	n 27 is ma er treuma		19a. Informant's Name/Relationship (Ty Richard Duckworth				and Number or Run ry Ridge Lan				
Baltimore, bermit. Pages 1 a Department of Hea	importent: if Item 27 is marke any injury or other treumatic <u>once.</u>		20a. Method of Disposition 1. Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State		esition (Name of matory or other place g Memorial		April 29, 2009	20c. Location Frost		wn, State Maryland
Dermit.	any inj		21. Signature of Funeral Service Licens	өө Ĵ	22	2. Name and Addre	ss of Facility ast Main Stre		n-McKenz aconing, N		eral Home P.A
	ician dical niner		23a. Parti. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line. a. Due to (or as a con	tepat		ng, such as cardiac	or respiratory arri	est,		Approximate Interval Between Onset and Death Security Pows
ß	g physicien and as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conduct. Due to (or as a conduct.							
death ce	or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			te ot delive onth	ory Day Year
aw requires that the	uid be detached f	۵	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.		es 2 \(\subseteq No	ribute to th	ne cause of death?
E &	page 2 should	Completed	hoart Fe	in live.	Neur	o pathy	/ \	24a. Was a autops perform	y ned?	Were autor prior to con death? 1 \(\sum \text{Yes}\)	psy findings available inpletion of cause of
	rector	o Be (25. Was case referred to medical examiner?	lospital:	_	. 3C POA Oth	26. Place of Deat	h (Check only on	в		
ding 4	funer	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur	y at	ome 5 Reside 28d. Describe ho			1
DIVISION of Attending after death.	d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)		_	28f. Location (St City or Town		er or Rura	l Route Number,
To the Hospitel or / within 24 hours after	letely filled in	Medical C	29a. Certifier 1 Certifying Physical Collection of 2 Medical Example 2	sician: To the best of my rer: On the basis or exan and manner stated.	knowledge, death nination and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and ma ate and place,	inner as sta and due to	ated. the cause(s)
To t within	сошр	M	29b. Signature and title of certifier	(Lemolhin	MW	29c. Licens	e number 14464		9d. Date signe 4/2	d (Month, L	Day, Year)
		8	30. Name and address of person who co	IR M.D.	48 /45	Print) n Terra	ce, Frust	Hury n	mylm	el o	21532
R	Sta egistra		31. Date filed (Month, Day, Year) APR 29 200	32. Registrar's Si	innature	miles		- /			
DHMH 17	Rev 1/20	01		- Johnson	10. 12.						

DHMH 17 Rev 1/2001

		Registrar	141. 1 . 1				rtificate	0, 500	41//	2. Date of	Reg. N	0.		3. Time of	(Dani)
ian	1	Decedent's Name (First, Mic		Lambor	rt Drum	mond				Month April	D.	ay .5	Year 2009		:25 p
ical iner	48	a. Facility Name (If not institute				mond	4b. City, To	wn, or Loca	tion of Death				of Death		
illei	ı	Arcola Nu	rsing	Home				Sil	ver Spr	ing			Montgo	mery	
	5.	Social Security Number	6. Sex		7. Age (In yr	s. last birthday)	If Under 1 Months	Year If U	nder 24 Hrs. urs Min.		Birth Day, Year	r)	9. Birthp Coun	lace (State	or Fore
r	L	185-01-0956	1 1 1	M 21X F	90	O Yrs.					28, 19		Penns	sylvani	.a
	\vdash	sual Residence of Decedent Da. State 10b. Cour	nty		10c. (City, Town or Lo	ocation						10	0d. Inside (Dity Lim
Ö		Maryland Mo	ntgome	oru				Silver	Spring	,				1 ☐ Ye	3 2 🕱
Director	10	De. Street and Number	льбош				10f. Zip C		- opra-a	<u> </u>	10g. C	Citizen of \	What Coun	try?	
a D		613 Symphor	y Wood	ds Drive	e			209	901				U.S.A	•	
To Be Completed by Funeral Director	1	I. Marital Status	1	12. Was Dece Armed Fo	edent Ever in	U.S. 13.	Was Decede	nt of Hispan Cuban, Me	ic Origin? (Spexican, Puerto	pecify Yes or o Rican, etc.)	No-		ce - Americ		
by Fu	١.	1 ☐ Never Married 2 ☐ M 3 🗷 Widowed 4 ☐ Divorce		1 ∐Yes If Yes, Gi Year or D	2 X No ve		1 □Yes 2		ecify:			Specify	y:	T hite	
Completed		15. Deced	lent's Educ	cation			dent's Usual kind of work		most of work	kina	16b.	Kind of B	usiness/Ind	dustry	
nple	-	Elementary/Secondary (0-12		College (1	1-4or 5+)	life.	DO NOT use	retired)		9					
S	H	12	//- / 4)				Claim	s Adjus	ster Mother's Nam	- (Eirot Mid	dla Maida		Insura		
B	111	7. Father's Name (First, Midd						18.1	viotners ivam	ie (<i>First, Mil</i> d	uie, iviaide	eri Surrian	u u	kn	
၉		9a, Informant's Name/Relatio	an Lami			10b Maili	ng Address (Stroot and A	lumbar ar Bu	ural Pauta Nu	mbor City	ar Town	State Zin	(Code)	
			,	_			Symphon								
	2	Rose C. Arnold Da. Method of Disposition	1 - NIC	ece	20b	Place of Dispo	sition (Name	of	bilve,	Date			- City or To		
		1 ☐ Burial 2 🗷 Crematio 4 ☐ Donation 5 ☐ Other		emoval from		cemetery, cre	•		0/./	22/2009	Pro	ntrao	d, Mar	wl and	
A		Signature of Funeral Service		9	1/1	t. Linco	2. Name and	Address of	Facility			IILWOO	u, nai	yranu	
N I		Nauca 1	1) #= 0-# =	+	I	Hines-Ri L1800 Ne	naldi E w Hamos	uneral	Home, I	nc. ilver	Sprin	g. Mar	vland	2090
	2	23a. Part 1. Enter the discase, shock, or hear life e. L	or complic	cations that one cause on e	caused the de									Approxima	ate etween
2	1 6	mmediate Cause (Final lisease or condition	,		umonia									Onset and	
	r	esulting in death)			(or as a cons	equence of):									
_	5														
ခု		sequentially list conditions,	b		,										
	if	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	┛゚	Due to	(or as a cons	equence of):			- 1						
xamir	if C tl	dequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	{ .		(or as a conse										
al Examiner	ti	ause (Disease or injury nat initiated events							- 1						
edical	ti r	ause (Disease or Injury nat initiated events esulting in death) Last	1 c												
edical	ti r	Jause (Disease or Injury nat initiated events esulting in death) Last	C c c	Due to	(or as a conse	equence of):		ugnanev					ate of delive		
edical	ti r	ause (Disease or Injury nat initiated events esulting in death) Last	2:	Due to Due to 3c. If yes, our 1 Live 4 Preg	(or as a consector of pregonant at time of	equence of): gnancy etal death 3	□ Ectopic pre						ate of deliver	ery Day	Year
edical	ti r	ause (Disease or Injury hat initiated events esulting in death) Last F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		Due to Due to Control Due to Due to	(or as a conso	equence of): gnancy stal death 3 f death 5	□Other (spe	cify)				Me	onth	Day	
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DHMH 17 Rev 1/2001

			State of Mary	land / Department of Health and N Certificate of Death	2000 14/28
		8	Decedent's Name (First, Middle, Last)	- Commonto or Boam	Reg. No. 2. Date of Death 3. Time of Death
	Physici		Wayne Deweese		April 13 2079 4:05 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		× -	10207 Coolfont Cros	ssing New Marke	t Frederick
#1.	Funeral			yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Yrs. World's Day's Hours Will.	Oct.11, 1952 Connecticut
	/land			c. City, Town or Location	10d. Inside City Limits
	Mar.	ţċ	Maryland Frederick	New Market	1 Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a		10207 Codfront Crossi	ng 21774	United States
	er de	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	of the specific Cuban Mexican Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland turel', or Iteme 23e or 28e-f show at Exacultar must be rediffed at	by F	1 Never Married 2 Married 1 Ves 2 No ff Yes, Give 3 Widowed 4 Divorced Year or Dates:	G7S 1□ Yes 2No Specify:	Specify: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
21215-0036	72 hours "natural",	ed	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	
2	TO 100 10 100	Con		Computer Specialis	ot Government
Maryland		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
Za		2	Willie Deweese		ne Bessette
Mai	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	A COMPANY OF THE PARTY OF THE P	al Route Number, City or Town, State, Zip Code)
	1 an Heel ern 2 ther		Jessica Kosevear / Daught 20a. Method of Disposition	Ob. Place of Disposition (Name of	Date 20c. Location - City or Town, State
noi	0 0 = =		1 D Burial 2 Comption 2 D Bamayal from State	stauffer Crematory 04/19	
Baltimore	글 분 본 글 .		21. Signature of Funeral Service Licensee	22. Name and Address of Ficility	Stauffer Funeral Home
ñ	Depa Depa Impo any la		Raymon Release	en 1621 Opossumtous	on Pike, Frederick; MSZ170Z
			23a. Part1. Eper the disease, or complications that caused the shock, of heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition	derotic Cardiovascular	Oncet and Death
	/Medical Examiner		resulting in death) Due to (or as a co		(30.0
В	LAdminer	L,	Sequentially list conditions, b		
	bed isr	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):	
	be executed icien end burial-transit	xar	that initiated events c	nsequence of):	
8760,	cate be executed bhysicien end the burial-transit				
9	tificate ig physi as the	Physician/Medical			
Вох	death certific e attending p ed for use as (an/N	## FFEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □		23d. Date of delivery
O. E.	D 0 0	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time		Month Day Year
P.O.	by ac	Phy	9 🗆 Onknown		200 Distribution of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of th
	ires tha signed d be det	by	Part II. Other significant conditions contributing to death but no Hypertension	it resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Sor	w require been si should b	etec	TI OFFICE TO THE TENT		
Rec	ne lav s has ge 2 :	Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ā	rician: Th certificate rector, pag		25. Was case referred to medical		1 Yes 2 No 1 Yes 2 No
5	Physician: r this certific ral director,	To Be	examiner?	2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 ★ Residence 6 □ Other (Specify)
0	ding Phye h. After this funeral di		27. Manner of Death 28a. Date of Injury		28d. Describe how injury occurred
ior	Attending ir death. ector: Aftei by the fune	atio	2 ☐ Accident investigation	M 1 Yes 2 No	
Division of Vital Records,	or Atti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S.	At home, farm, street, factory, office pecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	urs al urs al aral D		20.00		
	Hosi 24 ho Fun stely f	edicai	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)	/ knowledge, death occurred at the time, date and place, mination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of pertitler	29c. License number	29d. Date signed (Month, Day, Year)
	- > - 0		Ally Folires. MD"	DME D31197	Anvil 15.700
7	12+1		30. Name and address of person who completed cause of death	(Item 23a) (Type, Print)	inpini Diac
	8		Alan Rohrer, ND DME 15	West To Street, Frede	rick, MD 21701
2	Sta		31. Date filed (Month, Day, Year) 32. Registrar's S		
1997	Registr	al .	APR 20 2009 Sendan	W. Marane	

DHMH 17 Rev 1/2001

			1- For pgcbj State pgcbj RegistrarAmend#4	la Po	State	Mai	ryland	d / Depa	artmer	nt of H	ealth a	and M	ieni		giene Reg. No	2007	projection of	4229
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	Physicia		Vader	Δ	Del	nat	-ch							Month pril	. 03		081	17 A M
	/Medic		4a. Facility Name (If not instituti	on, give s				Karer	4b. City	Town, or	Location	of Deeth				. County of Deatl		
	Examin	eı	Wolker Mil	++	ealth	Cev	ter	Blvd	COCT	1 4 1	Hat.	SM				PG		
	Funeral		5. Social Security Number	6. Sex				ast birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. C	ate of Birt Month, Da	h v Year	9. Birtl	nplace (State or Foreign
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	2		Usual Residence of Decedent					T										side City Limits
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	8a-f	cto						715(1.1		E CH					10c C	itizen of What Co	untn/2	
	vith th	<u>Pire</u>	10e. Street and Number							p Code 0747					-	.S.A.	unity:	
	s 23	Funeral Director	1561 Karen Blvd		12. Was Dec	adopt E	vor in LLS	2 13		edent of Hi	spanic Or	rigin? (Sp	ecify	Yes or No		14. Race - Ame	rican Inc	tian,
	ter de	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐		Armed F	orces?		. 13.	If Yes, sp	ecify Cuba	n, Mexica	n, Puerto	Rica	n, etc.)	,	Black, White	e, etc.	
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0	should be filed within 72 hours after death with the Maryland and Mentylene. And Mental Hygiene. An arranged other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, it a Medical Examinar mainteen south	2	Robert Lee Wats	<u>on</u>								fie R						
_	C/ co = 00		19a. Informant's Name/Relatio													or Town, State, 2	cip Code	9)
2	1 and Health Iam 27		Evelyn R. Deloato	11 – 12	augnier		20h BI	ace of Dispo			Ldie;		Date	العبيب		20748 Location - City or	Town S	itate
5	Pages 1 nent of H int: If ita ury or ot		20a. Method of Disposition 1 Disposition Disposition Disposition	1 3 □R	emoval fron	State	CE	metery, cre	matory or	other plac		04/09		09		nton, MD	101111, 0	
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Daitimo	permit. Pages 1 and Department of Heali Important: If itam 2 any injury or other once.		21. Signature of Funeral Service	Licens	Ill	NA	M			ech Ro						Services 0748		
			23a. Part1. Enter the disease, shock, or heart failure. L	or compli	cations that	ceused i	the death e.	. Do not en	ter the mo	de of dyin	g, such as	s cardiac	or res	piratory a	rrest,		Inter	roximate val Between
ı	Physician		tmmediate Cause (Final disease or condition		At	hros	cler	stic	hoar	+ 0	tisea	سا					C	et and Death
	/Medical		resulting in death)	(Due to	(or as a	consequ	ience of):				-						
	Examiner		Sequentially list conditions,	b	H	4pe	rten	ience of):	>								(oyrs
۲	p ji	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ł		1	4		, ,	4								10 urs
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XO	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE:	2	3c. If yes, o	utcome c	of pregna	ncy								23d. Date of de	livery	
ñ	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?				2 ☐ Fetal time of de		□Ectopic □ Other (pregnancy specify)						Month	Day	Year
j.	y th	iysi	1 ☐ Yes 2/ No 9 ☐ Unknown		9□ Unk	nown												
7	requires that the deven signed by the a hould be detached for	by Pt	Part II. Other significant cond	itions cor	ntributing to	death bu	t not resu	ulting in the I	underlying	cause giv	en in Part	i.		23e. Did	tobacco	use contribute to	the car	use of death?
Sp	n sig	d b												1 🗆	Yes	2 X No 3 □ P	robably	4 □Unknown
cord		Completed												24a. Was		24b. Were a	utopsy fi	indings available
ě	The la	E O												auto perfe 1 Yes	ormed?	death?		
VII	sician: The law certificate has t irector, page 2 s	a	25. Was case referred to med	cal							26. Plac	ce of Dea	th (Cl	neck only				
	Physician: r this certifica ral director, p	To B	examiner?	H	lospital:	Inpatier	nt 2 🗆	ER/Outpatie	ent 3⊡ [Oth	er: 4 □ N	Nursing H	ome	5 Res	idence	6 □Other (Spe	cify)	
וס ר	ig Ph ter th neral		27. Manner of Death 1 XNatural 5 ☐ Pen	dina	28a. Dat (Mo	e of Injur	y Year)	28b. Time	of	28c. Injur Wor	y at k?		28d.	Describe	how in	jury occurred		
Ö	andir ath. or: Al	atic	2 Accident inve	stigation					М	10	Yes 2	□No						
Division	al or Attending P s after death. I Director: After t d in by the funera	Certification;		ld not be irmined	28e. Pla buil	ce of Inju ding, etc	iry · At ho . <i>(Specif</i>)	ome, farm, s	treet, fact	ory, office			28f.	Location City or To	(Street a wn, Sta	and Number or R ate)	ural Rol	ite Number,
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	o the ithin (o the omple	Med	29b. Signature and title of cert	ifier	-	//			2	9c. Licens	e number	r			29d. D	Date signed (Mon	th, Day,	Year)
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	30		30. Name and address of pers	on who d	mpleted ca	use of de	eath (Item	1 23a) (Type		1.4	168	Addi	501	Roo	d 5	euth		
	()		Debra A	t			,	, , , ,	,	(apit	al H	1019	ints.	M	20743	5	
	Sta	ate	31. Date filed (Month, Day, Ye	ar)	32.	Registra	ar's Signa	ture			1)				

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		For	State of Ma	ryland /	Depa	rtment of H	lealth	n and M	ental Hy	gien	е		
		State Registrar			Cer	tificate of	Deatl	h		Reg. N	0.2000	0 11.22	-
	п	1. Decedent's Name (First, Middle, L	ast)						2. Date of De		av Year	3. Time of Death	U
Physicia /Medica		MARY INEZ DURANT							APRIL 1		2009 Year	10:50 A ^M	
Examine		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location				c. County of Dea		_
		Holy Cross Hospit	al			Silver					iontgome:	ry	
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last		If Under 1 Year Months Days	If Unde Hours		8. Date of Bir (Month, Da	th a <i>y, Year</i>	9. Bir Co	thplace (State or Foreigr ountry)	ח
Director		577-30-4907	10 W 201	_80	Yrs.				5/9/192	28	Gree	enville, GA	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits	_
Maryl f sho	ō	M- 1 1 D										1 X Yes 2□No	
the 7	Director	Maryland Prince 10e. Street and Number	George's	Lanc	lover	10f. Zip Code				10g. C	itizen of What Co	ountry?	_
3a of		7442 Village Gre	en Terr			20785			ī	Init	ed State	26	
death ms 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. W	as Decedent of H		Origin? (Spe			14. Race - Ame	erican Indian,	_
Irs a	þ	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Yes, specify Cuba □Yes 2∏XNo	an, Mexic Specif		Hican, etc.)		Black, White		
n 72 hou "natura	Completed	15. Decedent's l (Specify only highest g	rade completed)		6a. Decedo (Give k life. D	ent's Usual Occup ind of work done O NOT use retired	eation during mo	ost of workir	ng	16b.	Kind of Business	/industry	
withi jene. thar	E	Elementary/Secondary (0-12)	College (1-4or 5+)			tic Engi				ת	omestic		
filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Las	it)		Jomes	ore Bilgr			(First, Middle				_
Alenta Alenta rked tic ev	10 8	Otis Reeves, Sr.					Mar	У					
shou and N s ma		19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailing	Address (Street	and Num	nber or Rura	l Route Numb	er, City	or Town, State, .	Zip Code)	
and 2 ealth n 27 I		Jerome A. Durant	Sr. / Husba	nd 24	411 F	airlawn	St.	Temp1	e Hills	з,	Marylan	d 20748	
of He of He of the of t		20a. Method of Disposition 1 → Burial 2 □ Cremation 3	Damoural from State	20b. Place ceme	of Dispos	ition (Name of atory or other place	ce)	D	ate	20c. l	Location - City or	Town, State	
Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Spec		Harmo	ony M	emorial	!	4/21/	2009	Lan	ndover, l	Maryland	
permit. Departi Importa any infi		21. Signature of Funeral Service Lice	ensee)	- 1	Name and Address 38 Mar1b		-				.A. land 20747	
		23a. Part 1. Ent the disease, or con shock, or heart failure. List on	n lications that caused the	ne death. D	o not ente	r the mode of dyir	ng, such a	as cardiac o	r respiratory a	ırrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	SEPSIS									Onset and Death	
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Examiner		Sequentially list conditions,	b. CARCINO	MA									
P. # .	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a	consequenc	e of):								
ecut and -tran	хаш	that initiated events resulting in death) Last	c Due to (or as a		o of):								_
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ficate phys s the	edica												_
law requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 13 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal dea	ath 3 🔲	Ectopic pregnanc Other (specify) _	у				23d. Date of de Month	livery Day Year	
that the ed by detac		Part II. Other significant conditions	contributing to death but	not resulting	g in the und	derlying cause giv	en in Par	t I.	23e. Did 1	tobacco	use contribute to	o the cause of death?	
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sician: The certificate I irector, page	Re C	25. Was case referred to medical	Τ				26. Pla	ice of Death	1 ☐ Yes (Check only o		101	2 2210	_
nyslc direc		examiner? 1 ☐ Yes 2 🛱 No	Hospital: 1 ☑ Inpatien	t 2 🗆 ER/	Outpatient	3 ☐ DOA Oth	er: 4□ I	Nursing Hor	ne 5 ☐ Resi	idence	6 ☐ Other (Spe	ecify)	
Attending Physician: The r death. ector: After this certificate h by the funeral director, page	Certification: 10	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28t	o. Time of Injury	28c. Injur Wor	ry at k?	2	28d. Describe	how inj	ury occurred		
eath. or: A the fu	Ĕ	2 ☐ Accident investigation					Yes 2	□No					
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier (Check only one) 1 ☑ Certifying F 2 ☐ Medical Exa	Physician: To the best of aminer: On the basis of a and manner state	examination	and/or inv	estigation, in my	me, date opinion, d	and place, a death occurre	ed at the time,	, date a	nd place, and du	e to the cause(s)	
Vith With Com	Ž	29b. Signature and title of certifier	0,17			29c. Licens				29d. D	ate signed (Mon		
17		019	utal da	yanı	4	D	00	525	86		4/16/0	9	
C)		30. Name and address of person who				Print)							
15/		ayanti L. Patel	1500 Forest			Silver	Spri	ng, M	arylan	d 20)910		
State Registra		APR 2 1 2009 Year)	32. Registrar	s Sunature	1								

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 15 P. M 2009 OSRD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 Nursing Oak Garret land Dennett Roa Home If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□F 234-78-8176 59 Director Aurora, WV Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₹ No Director Garrett Kitzmiller 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1322 Shallmar Road 21538 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White 12 should be filed within 72 hours n and Mental Hygiene. 18 marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Coal Miner Coa1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ward Clayton Ervin Colleen Maxine Knotts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 pertment of Health a certant: If item 27 la 1322 Shallmar Rd., Kitzmiller, MD 21538 Debbie Ford, Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Leadmine Cemetery May 1, 2009 Leadmine WV permit.
Departr
Imports
any nit 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, 710 Church St., Kitzmiller, MD Kethiene Disc. The Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Physician /Medical Due to (or as a consequence of): Examiner betes 14 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Day in the past 12 months? Month Year signed by the atte 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2K No 1 ☐ Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 5 To the Hospital 16 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier De 2 1 VAO Name and address of person who completed cause of death (Item 23a) (Type, Print) Veril 10 12 V 0 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar THE REPORT OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day VICTOR HERMAN **EVANS** JR. 18 2009 0 8 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . NICOMICE SOLISBUM REGIONAL MEDRAL Censu If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1**X** M 2□ F 4, DEC. 1928 DELAWARE 222-20-3511 80 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 38314 MARLYN LANE 19975 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1∐Yes 2XINo Specify: WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER POULTRY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HERMAN VICTOR EVANS SR. MARY IRENE HUDSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38317 MARLYN LANE, SELBYVILLE, DELAWARE 19975 DAVID H. EVANS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BISHOPVILLE CEMETERY 4/22/09 BISHOPVILLE, MARYLAND 4 Domation 5 Other (Specify) 22. Name and Address of Facility 21. Signatur HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final eou Scrave peon disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: therescloses. Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ,2 100 3 ☐ Probably 4 🗌 Unknown 0 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 2 DN0 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 1 Impatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner eath 28d. Describe how injury occurred 28c. Injury at Work? Matural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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Examiner

Funeral

Director

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Department of Health an Important: If item 27 is any injury or other trau once.

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Certification: To

To the Hospital within 24 hours a To the Funeral D

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title of certiffer

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29a. Certifie

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29b. Signatur

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

anive. SALISBUMY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nnc1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Daniel L. Everett 2009 1945 Apri1 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Laurelwood Care Center Elkton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min Months Maryland Yrs 88 1920 **Director** 217-05-0004 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Cecil Colora Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 49 Boyd Drive 21917 Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 MYes 2 □ No If Fes, Give Year or Dates: War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify: ≥ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Block Operator Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter L. Everett Mary Blackiston ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Lowe/Niece 49 Boyd Drive, Colora, MD 21917 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If It eny Injury or o April 29. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 2009 Cl 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton 2009 Cherry Hill, MD 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 13MOUTIN ALZHE MERS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unide Tyring Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician; The lew requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 6000 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ∐Yes 1 ☐ Yes 2 No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 8e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospitel within 24 hours a To the Funeral C 12 Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (amingr: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

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21215-0036

Baltimore, Maryland

P.O. Box 68760.

Records,

Division of Vital

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

(Tout)

MAY 0 4 2009

on who completed cause of death (Item 23a) (Type, Print)

₱32. Registrar's Signature

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DR Suite 105

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NEVARK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2009 April 23 **Physician** 7:00 Рм Rosalie Virginia Ebberts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Health Care Center Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1925 **Funeral** Hours Months Days 1 □ M 2 🗓 F 83 Maryland Sept. Director 219-20-3529 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, it is Medical Evariner must be notified at appear. Once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1421 Taney Avenue, Apartment 509 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence E. Jewell Bessie E. Toberv ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Winpigler / Niece 5640 Stone Road, Frederick, Maryland 21703 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 27 Mt. Olivet Cemetery 2009 Frederick, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licenses MO1473 106 E. Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** IWERK Dreuman. disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useas or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician s the burial Physician/Medical attending p for use as t IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown 2 No ficate has been si 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page 2 **X**No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1□Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number D0051643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Dr Frederick, MD 21702 State Registrar

Physician /Medical Examiner

Funeral Director

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1 - For State Registrar	State of Ma	-	epartment of F Dertificate of			ene 009	14235
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	6. Sex 7. Ag	e (In yrs. last birtho	fay) If Under 1 Year		8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign country)
217-18-4792 Usuat Residence of Decedent	X 8	7			5-23-	21 MD)
MD Alled	rany	10c. City, Town of	r Location				10d. tnside City Limits 1
10e. Street and Number	Jany	Weble	10f. Zip Code		10	g. Citizen of What Co	ountry?
301 Marsh Av	7.		2156	52		USA	·
11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 227 1 If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of Hit Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
15. Decedent (Specify only highes Elementary/Secondary (0-12)	grade completed)	(0)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	durina most of work	king	6b. Kind of Business	/industry
12	College (1-4or 5		eamstress	5		Garment	Industry
17. Father's Name (First, Middle, L	.ast)				e (First, Middle, M	·	
Harvey Mell:	inger			Blanch	e Beckm	an	
19a. Informant's Name/Relationsh			lailing Address (Street				
Mary Welch 20a. Method of Disposition	Daughter	-	619 Queer isposition (Name of				
1 Donation 5 ☐ Other (Sc	3 □Removal from State	cemetery,	crematory or other pla	ce)		Keyser,	
21. Signature of Funeral Service L		TOCOMO				Funeral	
William H.	Fredlocht					WV.2675	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2Æ No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	,		23d. Date of de Month	livery Day Year
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2 Accident investig	ation		M 1 🗆	Yes 2 □ No			
4 Homicide determine		ıry - At home, farm :. <i>(Specify)</i>	, street, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
29a. Certifier 18 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and/o	eath occurred at the tile or investigation, in my c	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as te and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mont	th, Day, Year)
▶ Salsah	at Na	maly	0000	58655		4/21/20	09
30. Name and address of person v		/ / /	, ,				
Sabahart Na 31. Date filed (Month, Day, Year)			Walsh Dr	. Cumbe	rland,	MD 21502	
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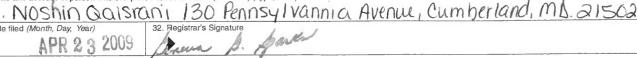
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 2 Day 0 gar **Physician** 0719 AM William Henry Fazenbaker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS 9. Birthplace (State or Foreign Country)

Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1 M 2□ F Months Days November 19, 1925 Director 220-16-2515 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show If e Medical Examirer must be notified at 1 Yes 2 □ No Director Lonaconing Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21539 43 Church Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded to 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) County Roads Supervisor 9 ages 1 and 2 should be filed a ent of Health and Mental Hygis nt: If item 27 is marked other i y or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Bid Hugh Fazenbaker ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daryl Fazenbaker - Son 13601 New Georges Creek Road, Frostburg, Maryland, 21532 Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 April 25, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Moscow Mills, Maryland Mountain View Cemetery 2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A. Brand Lonaconing, MD 21539 halm 8 East Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. LRESPIRATIONS Immediate Cause (Final SEVERE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury True to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year for 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Ö 9 \ Unknown 9 Unknown ο. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by CAD 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 2-No 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After the 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10064167

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15, Day 2009 **Physician** Webb Faison 12:33 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth
(Month, Day Vear If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1929 Months Days Hours North Carolina 301-22-2589 79 August Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County s 1 and 2 should be filed within 72 hours after death with the Maryla of Heatth and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting must be notified at 1≛Yes 2□No Director Prince George's Maryland Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 U.S.A. 5000 Lydianna Lane Apt.#205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10/25/45 If Yes, specify Cuba If Yes, Give 2/20/1947 1 □ Yes 2⊠ No Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 Specify: \$ 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Supervisor Posner Industry 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lolly or other traumatic event once. 17. Father's Name (First, Middle, Last) Fleet Faison Pearl Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6311A Panda COurt Waldorf, Maryland 20603 Ruth Banks (Executrix) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/22/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4217 9th Street, N.W. Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🔲 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a P.O. 2 \square No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 21 No as been signal 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2 🗷 No 1 ☐ Yes or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only onle) examiner? 1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural est hom MAISH9 2009 10,00M 1 ☐ Yes 2 ☑ No death. 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 500 Lyd Anna LANE 4705, Switting M determined 4 Homicide home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D4760x 4/16/2009 SO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3048 Mitchellville ROad Bowie, Maryland Sobhan Mathew, M.D.

DHMH 17 Rev 1/2001

State

Registrar

pate filed (Month, Day, Year)

park

Mary Elva Forsythe Mary Elva Forsythe 4a. Facility Name (If not institution, give street and number) Coffman Nursing Home 4b. City, Town, or Location of Death Hagerstown Washington To Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) O. F. Country) Physician Month Day Year O. F. Country O. F. Co			For State Registrar 1. Decedent's Name (First, Middle, La.	State of Maryl	and / Depa	artment rtificate	of He	ealth ar Death			Reg. No.	9	3. Time of Dea
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24a. Was an autopsy findings available of completion of cause death? 25. Was case referred edical examiner? 1 Yes 2 No 25. Was case referred edical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Mann Death 1 Satural 5 Pending investigation 28a. Date of Injury 28b. Time of Injury M Vork? M 1 Yes 2 No 28b. Time of Injury at Work? M 1 Yes 2 No 28b. Time of Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	y the attending piched for use as:	ysiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 2 Yes 2 No	1 ☐ Live birth 2 ☐ ☐ 4 ☐ Pregnant at time	Fetal death 3								-
autopsy performed? 1 Yes 2 No Yes 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes	an signed b uld be deta		Part II. Other significant conditions of	contributing to death but no	t resulting in the u	nderlying ca	ause give	n in Part I.				-	
27. Mann Death 1	03 CA	Complet								autop	osy ormed?	prior to death?	completion of cause
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	두교	To B	examiner? 1 Yes 2 No 27. Mann Death 1 atural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28	8c. Injury Work	at	sing Hom	ne 5 🗌 Resid	dence 6 🗆 O		ecify)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	al Director: ad in by the	Certifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury -		reet, factory	, office		2	8f. Location (City or Tox	Street and Nun wn, State)	nber or R	lural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 20; 2009	the Funer	edical	(Check only 2 Medical Examone)	niner: On the basis of exam	knowledge, dea mination and/or in	vestigation,	in my op	inion, death	l place, a h occurre	nd due to the d at the time,	date and place	, and du	e to the cause(s)
	Tot	Σ	> SAMUEL C	han									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4/21/2009 1.05 P Marvin Mitchell Foxwell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Chesapeake Woods Center Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F Maryland 218-20-8557 82 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Extrait nativust be rutified at 28a-f show 1 XYes 2 ☐ No Director Dorchester Cambridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 740 Foxtail Dr., Apt. 308 21613 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1944 -13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 ☐ Widowed 4 🔀 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Boat Captain** 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Louis Hubbard Foxwell Grace Shorter ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 1807 Hudson Rd., Cambridge, MD 21613 Milford Mace Foxwell, Jr. / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4/22/2009 Cambridge, MD Mid Shore Cremation Center 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sep-Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a fonsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as i attending properties for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) signed by the a 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🛂 No 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊡ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 1 Natural 5 Pending ours after death. neral Director: Ai filled in by the fu 1 TYes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/21/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 CIVIC AVE., SALISBURY, MD 21804 WILLIAM HAMILTON ROBINS, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

31) DHMH 17 Rev 1/2001

Dic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 12:55 P_M 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Nettie GARDNER 17, April 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery Casey House Montgomery Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1□M 2X□F Dec. 10, Pennsylvania 89 201-10-5602 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Rockville Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 14421 Traville Garden Circle United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white 1 ☐Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Dorfman Morris Segal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1680 Huntington Pike, Huntington Valley, PA Mitchel Gardner, Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/20/09 Trevose, PA Roosevelt Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Lic _22. Name and Address of Facility Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 Days Intracerebral Hemorrhage resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f shovener must be notified at

d other than "natural", or i event, the "Audical Examir

permit. Pages 1 and 2 should be filed withi.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than
any Injury or other traumatic event, the Mental

Director

Funeral

Completed by

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ner Exami by Physician/Medical

and attending physician for use as the buria signed by the a Completed cate has page 2 s certificate Be To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Division of Vital Records, P.O. Box 68760,

certificate be

Physi	9 ☐ Unknown	9 Unknown	
þ	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown
Completed			24a. Was an autopsy performed? 1 □ Yes 2 ▼No 2 1 □ Yes 2 □ No
	25. Was case referred to medical	26. Place of Death (C	Check only one)
To Be	examiner? 1 ☐ Yes 2 🛣 No		5 ☐ Residence 6 ★ Other (Specify) Hospice
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not to determined		Location (Street and Number or Rural Route Number, City or Town, State)
lical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

50063748

29d. Date signed (Month, Day, Year)

April, 17, 2009

20855

State Registrar

Medical

29b. Signature and title of certifier

Jocelyn Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 20 2009 ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009	4	2	4
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		- For State	J	Certifi	icate of	Death		,,,	Reg	. No	200		I form I
Physician	1	1. Decedent's Name (First, Middle,La						M	ate of Death	Dav	Year	3. Time of Death 1223 hrs	1
Medical Examine		Rode 4a. Facility Name (if not institution, gi	eric Dale	Gill		o. City, Town, or	Location of D		oril 17, 20		unty of Deat	<u> </u>	
		University Hospital	e street and names,		"	Baltimore							
Funeral	1	5. Social Security Number 6. S	ex 7. Age	e (In yrs. last i	birthday)	If Under 1 Yea		4Hrs. 8. I	Date of Birth	(MM/DD/Y	Forei	irthplace (State or ign	
Director		006-30-6225 1\(\bar{X}\)	M 2 F	75	Yrs.	Months Day	/S Hours	IVIII).	May 1	+, 19	33 C	ountry) Maine	е
è	_	Usual Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Locatio	on .						10d. Inside City	Limits
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arylan 8a-f s	u ∟	10e. Street and Number				10f. Zip Code		_	10	g. Citizen	of What Cou	untry?	
ith the Maryland 23a or 28a-f show any notified at once.		459 Camp Meeti	ng Ground	Road		2	1904				U.S.,]
th with	Funeral	11. Marital Status 1 Never Married 2 X Marrie	12. Was Decedent Armed Forces?			Decedent of Hi s, specify Cuba					Race - Ame White, etc.	erican Indian, Black	ζ,
er dear			1XX Yes 2	No E6_E8	1	Yes 2XX No	o specify:			Spe	ecify:	White	
215-0036 be filed within 72 hours after death with the Maryland nat Hygiene. rked other than "natural", or items 23a or 28a-f she cut, the Medical Examiner must be notified at once	핡	15. Decedent's Education (Specify of			Sa. Decedent	's Usual Occupa	ation (Give kine	d of work	done		of Business		
5-0036 sed within 72 hours tygiene than "natur the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	Cl	ost of working life nief, Da	ata Bas	e				cal Cente	
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y, MD 21215-003 and 2 should be filed withitell had Mental Hygiene, treu 27 is marked other traumarties or the Mental Hygiene.		Rose Marie Roy G	illis (wi			<u> </u>		ound				osit, MD	
S 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from St	ate cre	matory or oth								
	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Like		Нор		Ceme te l		04/2	4/09	Port	Depo	sit,Mary	land
Balt permit. Depart Import	1	21. Signature of Funeral Service Lice	THAT W	$m \leq 1$	L	ee A. Pa	atterso	n &	Son Fu	unera	1 Home	e, P.A. 0766	
Physician	Ť	23a. Part I. Enter the disease, or confailure. List only one cause on	iplications that caused	the death. D	o not enter th	ne mode of dying	, such as card	diac or res	piratory arre	est, shock,	or heart	Approximate I Between Ons	
'Medical kaminer	ł	Immediate Cause (Final disease	a. Gunshot Wound	d of Head								Death	1
	-	or condition resulting in death)	Due to (or as a cons	equence of):									
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760, cate be executed physician and he burial - transi	Medical	UNPENDED	AMENDED	<u>.</u>									
8760, ifficate being physici		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	me of pregna		tal death 3	Ectopic p	regnancy			Date of delive onth		ear
Box 68's death certiff	sician	past 12 months?	4 Pregnant at	t time of deat		her (Specify)				1			4
the dea	Phys	Part II. Other significant condition	9 DIKIOWII	th but not resi	ulting in the u	inderlying cause	given in Part	l.	23e. Did to	obacco use	contribute	to the cause of de	ath?
P.O. es that	ρ					, ,	_		1 Yes	2 🗸 N	lo 3 P	Probably 4 Uni	known
rds, requir	etec			-					24a. Was		24b. Were	autopsy findings a to completion of ca	available ause of
eco he law tte has	Completed				-11 -			_		rmed?	death	?	No
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Vita	10 B	examiner? 1 ✓ Yes 2 No	Hospital: 1 V Inpati		R/Outpatient			Nursing H	d. Describe	Residence		her:	
Division of Vital Records, P.O. Isla or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	E .	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Day) Apr 17, 2009	Year)	28b. Time of 1 1057 hrs	· · -	ijury at Work? Yes 2 ✔ 1	lsu	ibject sho		occurred		
iSio	icat	2 Accident Investig	ation 28e Place of I	njury - At hom	ne, farm, stre	et, factory, office	e building, etc.	. 28			Number or	Rural Route Numb	ber, City
Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 ✓ Suicide 6 Could n determin		ngle Fami	ly	_		459	or Town, S 9 Camp Me	eeting Gr	ound Road	d, Port Deposit,	MD
		29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of n	ny knowledge	e, death occu	rred at the time,	date and plac	e, and du	e to the cause time, date	se(s) and r and place	manner as s	tated. the cause(s)	
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated				nse number					Month, Day, Year)	
	_	Dande	- Iw			0.0	C.M.E.			April '	18, 2009		
		30. Name and address of person wh		death (Item 2						1			
8		Donna M. Vincenti, MD	Assistant Medi			1 Penn Stree	et, Baltimo	re, MD	21201				
Sta Regist		31. Date filed (Month, Day, Year)	- //	ar's Signature	bare	1							
-		HT II	100	7									

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** JANE GRIFFITH 10:00P.M APRIL 20 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner REEDERS MEMORIAL HOME BOONSBORO WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Director 214-34-9573 MARCH 15, 1921 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Funeral Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be 14 SCHOOLHOUSE COURT 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 ☐ Divorced WHITE the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 SEAMSTRESS CLOTHING MANUFACTURE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi lealth and Mental F Is marked JOHN SIEBERT MARSHALL ၉ MARTHA ELLA ELY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I 146 LANTERN LANE, CHAMBERSBURG, PA JOYCE Y. QUINN/DAUGHTER permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other: Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Byrial 2 Cremation 4/24/2009 5 ☐ Other (Specify) MOUNTAIN VIEW CEM. SHARPSBURG, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signature of Paul M. Dean 7606 Old National Pike, Boonsboro, MD 23a. P. 11. Enter the diseas — complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myo Cardwel disease or condition resulting in death) 1 HR /Medical Du o (or as a consequence Examiner Cardio YEARLY. Premier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed faller that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an page 2 has autopsy The performe certificate 2 **X** No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No death. the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

Registrar

State

20311 LAPPANS ROAD

32. Registrar's Signature

BOONSBORO, MARYLAND 21713

301-432-8470

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GHAZALA QADIR,

VDB 5 3 3400

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS, G891,5/6/09, WS
State of Maryland Department of Health and Mental Hygiene

Amend #5, per FH g895

Certificate of Death

Reg. No.? [] [] S 1 - For State Registrat 2. Date of Death 1. Decedent's Name (First, Middle, Last)

Doris Anne Grempler

Doris Ann Grempler **Physician** 8:38 p M 4/18/2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 7204 Kidmore Lane Lanham 5. Social Security Number 9575 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🖼 F 9/19/1928 Washington, DC 80 579-34-Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 7. marked other than "natural", or items 23a or 28a-f show traumatic event, it a libraries Examiner must be notified at 1 TxYes 2 □ No Lanham MD Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20706 7204 Kidmore Lane Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iter 1 ☐ Yes 2 No 1 Never Married 2 Married 1 □Yes 2X No Specify: White 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify 2 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Private</u> 12th Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marian M. Mears Eldridge Albert Sherbert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Empire Pl. Greenbelt, MD 20770 Brian Grempler/Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iten any injury or ott once. 1 Burial 2 Cremation 3 Removal from State 4/23/09 Brentwood, MD Ft. Lincoln Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of uneral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1∐ Yes 2√ No Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical nt to be best of information and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner (Check on one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 226 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0) Richard Feldman 9500 Annapolis Road #A4, Lanham, MD 20706 32. Registràr's Signature faces State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelibite onk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 15 2009 7:55 A 04 Bernice Bell Garnett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 9707 Grayson Ave. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 012-24-8574 6. Sex **Funeral** Months 1 □ M 2 🛛 F 82 02/28/1927 NC 24 Director 8514 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County works. at 1 ☑ Yes 2 ☐ No r 28a-f sh notified Funeral Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or ms 23a 20901 9707 Grayson Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give "natural", or Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 → Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than the M Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Infury or other traumatic event, the M once. Raytheon Corporation 11 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Jane Cannaday Louis Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9707 Grayson Ave. Silver Spring, MD 20901 Ilene L. Garnett/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Shady Grove Baptist 4/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Orange County, VA Church Cemetery 22. Name and Address of Facility Marshall's Funeral Home Funeral Service Licensee 21. Signatur 4217 9th St NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 XNo ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown High Blood Pressure Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an autopsy performed? Yes 2 🔼 No has 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 0 after within 24 hours a To the Funeral L Hospital 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D33159 04/17/2009 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 8700 Georgia Avenue Suite 400 SIlver SPring, Md. 20910 Ruth Kevess-Cohen, M.D. 31. Date filed (Month, Day, Year)

State Registrar APR 2 1 2009

32. Registrar's Signature

A. Aparlis

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month 2009 2318 ^M APRIL 16, EVELYN GODWIN D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER | SERLLIN | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAY | 12, | MAY | 12, | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F MARYLAND 262-54-4189 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Eventual Traumatic and once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MARYLAND WORCESTER BISHOPVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12106 COLLINS ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married //6/2009 € 2318 Maryland 21215-0036 1 ∐Yes 2 XNo Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLA OUILLEN THOMAS HAMMOND ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANCY E. LATHBURY/SISTER 10017 HAMMOND ROAD, BISHOPVILLE, MARYLAND 21813 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROXANA CEMETERY 4/21/09 ROXANA, DELAWARE 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Coronary Artery Directl Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Diabetes physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) o been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has b rector, page 2 st was ...
autopsy
performed? 2 No Vital 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other. 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Medical Certification: To ō After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending Pt 24 hours after death. e Funeral Director: After the 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0067227 12 dr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danielle 11107 Race Wack MD 21811 Rd 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 20 2009 park Leneva Registrar

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			Registrar Certificate of Death						Reg. No. 4	0 2	14670
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	and and		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
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ore	of H of H f Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	20b. P	lace of Dispo emetery, crei	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or To	own, State
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		2:	2. Name and Address David A.	ss of Facility Burdock	Funera	1 Home.	P.A.	
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Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	determined 28e.	Pla <i>ce o</i> f Injury - At ho building, etc. <i>(Sp</i> ec <i>if</i>)	ome, farm, sti iy)	eet, factory, office		28f. Location City or To	(Street and Numb wn, State)	er or Run	al Route Number,
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	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: On and	the basis of examina							
	the the	Med	29b. Signature and title of cextifier	manner stated.		29c. Licens	e number		29d. Date signe	d (Month	Day Year)
	7.≥		Loss of the title of continer	_							
		اسر				D239	9/9		4/28/20	109	
		5	30. Name and address of person who completed	,		•	Oalel and	MD 215	550		
	Cia	•	Robert A. Goralski, N 31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	Street, (Jakrand,	MD 215) J U		
	Sta Registr		APR 2 9 2009	Olyna	A	barker					
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Gladys Rau Hughes 3:30a M April 17 2009 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 486-03-3318 1 □ M 2 🗓 F 93 Yrs. March 22, 1916 Director MO Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Silver Spring Director Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ LISA 20904 3152 Gracefield Road, MS #201 , or items 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2XNo If Yes, Give Year or Dates Specify. Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Co-co 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Nellie Giacalone Joe Richinell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 g Department of Health ar Important; If Item 27 Is 22053 Hackney Circle, Lincoln, DE 19960 Lawrence E. Hughes / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Injury o Metropolitan Crematory April 21, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility any Ir Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Onset and 3 days Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed ysician and e burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical phys the t as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 호 in the past 12 months? 1 ☐ Yes 2 🖾 No 5 Other (specify) P.0. ed by the 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate 1 □Yes 2XX No 2XXNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: or Attending 1 XNatural 5 Pending investigation after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the To the within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number April 17, 2009 D24093 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst M.D. 3110 Gracefield Rd., Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signat State 20

Registrar

			1 - For State of Maryland		artment of H		fental Hy	giene Reg. No. 2009	14248	
			Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day Year	3. Time of Death	
	Physicia /Medic		Elizabeth Hellmann				Apri	1 16, 2009	10:00 P ^M	
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea		
4			Brighton Gardens 5. Social Security Number 6. Sex 7. Age (In yrs. la.	et hirthday)	Chevy C	Chase If Under 24 Hrs.	8. Date of Bir	Montgome:	ry thplace <i>(State or Foreign</i>	
	Funeral Director		085-24-2306 1□ M 2X□ F 88	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year) Co .6, 1921 Cze	ountry)	
	ō		Usual Residence of Decedent					,	10d. Inside City Limits	
	arylar show	5		Town or Lo	cation				1 ☐ Yes 2¾ No	
	the M	recto	MD Montgomery Poto	omac	10f. Zip Code			10g. Citizen of What Co		
	3a or	Ö	8608 Stirrup Court		20854			USA		
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Hygiene. the than "natural", or Items 23a or 28a-f show ent, Ira Marical Examir et must be molified at ent.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.		ispanic Origin? (Sp	ecify Yes or No			
98	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		1 □Yes 2 No	Specify:	1 110011, 010.)	Specify: Whi		
21215-0036	hours tural";	ed by	3 □ Widowed 4 □ Divorced . Ye ar or Dates:	16a Docor	dent's Usual Occupa	ation		16b. Kind of Business		
.15	in 72 n "nat	plete	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of NOT use retired	furing most of work)	ing	TOD, KING OF BUSINESS	madaty	
212	d with giene er tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Но	memaker			Own Home		
D	<u> </u>	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surname)		
<u> </u>	should be filed vind Mental Hygis marked other umatic event, III	ဥ	Paul Robitschek				Oppenh			
10	2 s au is		19a. Informant's Name/Relationship (Type. Print) Claudia Esposito Niece		Stirrup (oer, City or Town, State, MD 20854	Zip Code)	
ď,	s 1 and f Health tem 27 other to				sition (Name of natory or other place		Date	20c. Location - City or	Town, State	
e E	Pages nent of int: If It		I II I Burial 2 I Cremation 3 I Hemoval from State I		Cremator	1)/09	Falls Chur	ch, Va.	
Baltimore,	permit. Pages Department of Important: If II any Injury or o		21. Signature of Funeral Service Licensee		2. Name and Address	(F - 22)		awler's Son	-	
<u> </u>	89 = 89		William K. Drigge			sin Ave.	N.W., V	Washington,	D.C. 20016	
			23a. Part 1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death	
F	Physician /Medical		Immediate Cause (Fine) disease or condition resulting in death) Meningioma 2007							
	Examiner		Due to (or as a conseque	ence of):						
		le.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):							
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events C							
760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a conseque	ence of):						
6876	death certificate be executed e attending physician and d for use as the burial-transit	dical	d							
X 6	leath certific attending p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnan					23d. Date of de	aliverv	
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 4 ☐ Pregnant at time of de		☐ Ectopic pregnanc; ☐ Other (specify)	4		Month	Day Year	
	at the by the tacher	hys	9 Unknown							
s,	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause give	en in Part I.		tobacco use contribute t		
00	requii	ted	End Stage Alzheimer's dementia					A	Probably 4 ☐ Unknown	
Records,	e la has e 2	Completed					24a. Was auto	psv prior to	utopsy findings available completion of cause of	
_			25. Was case referred to medical			00 Di (D	perfe 1 ☐ Yes		s 2 No	
Vital	Physician: r this certific ral director,	o Be	examiner? 1 □ Yes 2 ☑ No	B/Outnatier	ot 3 DOA Othe	26. Place of Dear		idence 6 🛣 Other (Sp.	assisted	
	iding Physician: th. After this certifical funeral director, p	<u> - </u>	27. Manner of Death 28a. Date of Injury	28b. Time o		y at		how injury occurred	ecify) living	
20	Attending ir death. ector: After by the funer	atio	2 Accident investigation	,,		Yes 2□No				
Division	or Attenation	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office			(Street and Number or F wn, State)	lural Route Number,	
	e Hospital or A 124 hours after o Funeral Direc letely filled in by		29a. Certifier 1 Certifying Physician: To the best of my know	ledge, deat	h occurred at the tir	me, date and place	, and due to the	e cause(s) and manner	as stated.	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examiner: On the basis of examinations) and manner stated.							
	To the i	Mě	29b. Signature and title of certifier)	29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)	
	t0		Shama R. mittal	MI) D000	61382		April 1	7, 2009	
			30. Name and address of person who completed cause of death (Item Dr. Sharna R. Mittal 5555 Fr:	^{23a) (Type,} iendsł	Print) nip Blvd.	, Chevy (hase, N	MD 20815		
	Sta	te								
	Registr	ar	APR 2 0 2009 Segistrar's Signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of the signature of th	. 400	With the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of t					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03053 State of Maryland / Department of Health and Mental Hygiene Gregory Hawks 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 16, 2009 1705 hrs **Medical Examiner** Gregory Allen HAWKS, c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Maryland Correctional Institute Hagerstown 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 212-78-8351 1 X M 2 49 Yrs June 28 1959 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No s 23a or 28a-f show e notified at once permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once Maryland Washington Hagerstown Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 18800 Roxbury Road 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces Never Married 2 Married Yes White 2 X No specify: 4 X Divorced f Yes, Give Year Specify Widowed Yes 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Residential/ Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Commercial painting 12 0 Painter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Clemens Hawks, Jr. Peggy Ann Lum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21740 Shawna Plotner - Daughter 09 Elm Street, Hagerstown, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 4/23/09 Hagerstown, Maryland Donation 5 Other Specify Signature of Funeral Service Licensee Minnich Funeral Home mes X. Spicer 415 E. Wilson Blvd. Hagerstown, Maryland Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Medical Death Immediate Cause (Final disease a. Pulmonary Thromboembolism xaminer or condition resulting in death) Due to (or as a consequence of) b. Deep Venous Thromboses Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atter 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Testicular carcinoma ficate has been si , page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medical

Division of Vital

certificate

Completed Be ို 27. Manner of Death Certification: 2

examiner?

1 V Natural

3

4

Medical

State

Registrar

1 ✔ Yes

Accident

Suicide

Homicide 29a. Certifier 1 (Check only one) 2

29b. Signature and title of certifier

Hospital or Attending Physician: 24 hours after death Funeral Director: After this certificately filled in by the funeral director, 1 To the I

Records, P.O.

1-HC

Melissa Brassell, MD 31. Date filed (Mont) 212

and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

Inpatient

28a. Date of Injury (Month, Day, Year)

(Specify)

and manner stated

Hospital:

32. Registrar's Signature

Charles .

ER/Outpatient 3

28e. Place of Injury - At home, farm, street, factory, office building, etc

28b. Time of Injury

Other₄

Yes 2 No

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Nursing Home 5

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

April 17, 2009

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

or Town, State)

Pending

Investigation

Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>09</u> Month Physician 8:15P April 16, Hughes Bernard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St Vincent Care Center Frederick Emmitsburg If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Feb 23, Pennsylvania 207-40-0577 89 1920 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Director Maryland | Frederick Emmitsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 USA 335 South Seton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo White If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic School Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Μ. McMenamin Thomas Hughes Jenny ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Artillary Drive, Gettysburg, PA 17325 Sr. Mary Adele White/Friend Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/22/09 Sister of Notre Dame Ellicott City, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home, PA - WM We 1621 Opossumtown Pike, Frederick, MD 21702 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mo **Physician** /Medical e to (or as a consequer co of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner r as a consequence of): The law requires that the death certificate be executed burial-trar consequence of): Box 68760 physician the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an this certificate has autopsy page 1 □Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death. Ieral Director: A filled in by the fu investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 24 hours a

To the Funeral C

completely filled

State Registrar

31. Date filed (Month, Day, Year)

Alan Carroll

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Emmitsburg, MD 21727

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indeliale lake Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 2009 **Physician** 11:50 A M 21, HOWARD STELLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Hours Months 1 □ M 2 🕱 F 92 220-12-8757 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the listical Examinar must be notified at 1 ☐ Yes 2 No Director Jarrettsville MD. Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 United States 2104 Wiley Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Department Store Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florida Singleton Charles Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau (Neighbor) Judith Bolt 2108 Wiley Road Jarrettsville, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jessops Cemetery 4/24/2009 Sparks, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) detached ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? 1 ☐Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

MAY 0 4 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

615 W. MACPHAIL ROAD

D32275

BEL AIR, MD.

21014

April 21, 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year B: 10 don. Robert Wayne Hendershot, Jr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 WV 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 1**X** M 2□ F 46Yrs. 219-80-9783 July 21,1962 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Washington Hancock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21750 USA 15011 Mountain Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12Correctional Officer State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna M. Carlisle Robert W. Hendershot, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Hendershot/Wife 15011 Mountain Road Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Buck Valley Christian 04/29/2009 Warfordsburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of uneral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUROGNOUCRINE MONTHS Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, if a Medical Evanitual runst be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

After t

within 24 hours after death

To the Funeral Director:
completely filled in by the t

Sequentially list conditions, if ny limb and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy ner (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1. SInpatient 2 ☐ ER/Outpatient 3	044	(Check only one) me 5 ☐ Residence	6 ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	'	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.					
29b. Signature and title of certifier		29c License number	29d Ds	ate signed (Month Day Year)		

Registrar
DHMH 17 Rev 1/2001

State

Scott Weeven

31. Date filed (Month, Day,

11110 megical Campus Ry STE 170 HAGERSTOWN, MD 2174/2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

mo

Year)

DHMH 17 Rev 1/2001

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month Johnson-Young **Physician** Α. 6:35 April 13, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Oxon Hill 1505 Javes Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Feb 9, 1936 Virginia 73 Director 227-52-9799 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the "hadical Exp. clink input he notified at 1 X Yes 2 □ No Director Temple Hills Maryland | Prince George's 10g, Citizen of What Country? 10e. Street and Number United States 20748 2405 Southern Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 🔀 🖔 Married Baltimore, Maryland 21215-0036 **Black** 1 □Yes 2 ₩Vo Specify: ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H Be Mary Black Joseph Hoskins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2405 Southern Avenue Temple Hills, MD 20748 Joshua Young - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery April 21, 2009 Brentwood, MD 4 Donation 5 ☐ Other (Specify) >22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral Service Ligense 21. Sia 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Atherosclerotic Cardiovascular Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 5 Other (specify) P.0. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 No certificate 1 □Yes Hospital or Attending Physician: director. 26. Place of Death (Check only one) Demohiter 25. Was case referred to medical examiner? Be Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify) Home 1A Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Injury 1[™] Natural 5 Pending investigation after death.

I Director; Af d in by the fur 1 □Yes 2 □ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

D

M.D. 3001 Hospital Drive Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester,

filed (Month, Day, Year)

APR 2 1 2009

2005

		For State Registrer	State of Ma	ryland / I	•	rtment of He tificate of E			Reg. No.	109	4250
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/Medic	al	James Richard Ke				th City Town on	Location of Dogth	April	21"	2009 ounty of Dear	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be relified at once.		· · · · · · .		g Address (Street a					, Zip Code)
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¥	Attending Physician: It death. ector: After this certific. by the funeral director, I		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatier	nt 3 DOA Othe	er: 4 🗆 Nurs	sing Home 5 🔀	Resider	nce 6 □Other (S)	pecify)
n 0	ng Pt ifter th	.uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year)	b. Time of Injury	Work	/ at ?	28d. Des	cribe hov	injury occurred	
sio	tendi leath. tor: A the fu	cati	2 Accident investigation	,		Yes 2 □ No		N (Q)		D / D / D /-
Division of Vital Records,	I or Attend after death Director:	Certification: To	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, rarm, str	eet, ractory, office		City	or Town,	State)	Rural Route Number,
1	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 ★ Certifying Physician: To the best of my knowled	dge, deat	h occurred at the tin	ne, date and	place, and due	to the ca	use(s) and manner	as stated.
	ie Hox 7 24 h ie Fur bletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or in	vestigation, in my op	pinion, death	occurred at the	time, da	te and place, and d	ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	200	29c. License				d. Date signed (Mo	nth, Day, Year)
	5		I fruit James		D0058	213		4	/20/2009	
	00		30. Name and address of person who completed cause of death (Item 23							
	GX.		Farhad Jamali, MD 7525 Greenway 31. Date filed (Month, Day, Year) 32. Registrar's Signature		er Dr., S	te 116	, Green	be1t	, MD 207	770
	Sta Registr		APR 9 1 (1815)		1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

enneth Minetter	State of Maryland / Department of Health and Mental Hyglene 1- For State Registrar Certificate of Death Reg. No. 2009 1425
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 26 North Main Street Smithsburg 4c. County of Death Washington
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	Usual Residence of Decedent
d c.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Md. Washington Smithsburg 1 🕱 yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	10e. Street and Number
215-0036 be filed within 72 hours after death with the Maryland antal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
fler death with I", or items 23 ter must be no Y Funeral	Never Married 1 Yes 2 No
2 hours a "natural Examin	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Lementary/Secondary (0-12) Lementary/Secondary (0-12) College (1-4 or 5+) Lementary/Secondary (0-12) Lementary/Secondary (0-12) College (1-4 or 5+)
5-0036 ed within 72 hours after tygiene. other than "natural" the Medical Examine Completed by	17. Father's Name (First, Middle, Last) Minister Church 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than event, the Medica To Be Complé	Harold K. Kilheffer Dorothy weaver
re, MD 21. I and 2 should the fitten 27 is mar or traumatic ever traumatic even.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 N. Main St. P.O. Box 834 Smithsburg, Md. 21783
10re, MD 21215-0036 ages I and 2 should be filed within 72 hours aften of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory Smithsburg, Md.
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify:
Physician	The figure of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart sellure. Est only one cause on each line. Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
Jer	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):
ted nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Due to (or as a consequence of):
60, ate be execute bhysician and re burial - tran	d. UNPENDED AMENDED
ox 68760, bath certificate be executed attending physician and for use as the burial - transit sician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
). Box 687 the death certific by the attending i ched for use as if	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) g Unknown
, P.O. res that the signed by the be detache d by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be Completed	24a. Was an autopsy findings available prior to completion of cause of
Vital Reco	performed? 1 V Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
F Vital Physicians This certificated director	examiner? 1 ✓ Yes 2 No
ion of Vending Pheeath. Interpreted the funeral ation: To	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Division o spital or Attending tours after death. Tilled in by the fune filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	4 Homicide (Specify)
To the Ho within 24 To the Fu complete!	29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)
0045	30. Name and address of person who completed cause of death (Item 23a)
OCME	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	

		State of Mary		partment of H			000	0 11050
		Registrar 1. Decedent's Name (First, Middle, Last)		erinicale or i	Dealii	2. Date of Dea	th	3. Time of Death
Physicia			IRBY			Month APRIL		'ear
/Medic Examine		4a. Facility Name (If not institution, give street and number)	INDI	4b. City, Town, or	Location of Deat		4c. County of	
Examin		PRINCE GEORGES HOSPITAL CE	NTER	CHEV	ERLY		PRIN	ICE GEORGES
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		If Under 24 Hrs Hours Min.	8. Date of Birth	3 9	Birthplace (State or Foreign Country)
Director		443-82-8726 ^{1∑M 2□ F}	41 Yrs.	World Baye	110010	JULY 1,		MARYLAND
and	}	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or	Location				10d. Inside City Limits
Maryl f sho	ō	DRIVER GEORGE		T A NULL AND				1 X Yes 2 □ No
the 1	Director	MD. PRINCE GEORGES 10e. Street and Number		LANHAM 10f. Zip Code			10g. Citizen of Wh	at Country?
h with		8610 OLD BROWN LA.		20	706		U.	S.A.
deat	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S.	B. Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Race -	American Indian, White, etc.
after or ite		1 Never Married 2 Married 1 Yes 2 No		1 ☐Yes 2 No	Specify:	to Filoati, otoly	Specify:	
nours ural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10 0					WHITE
"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	ı (Gi	cedent's Usual Occup ve kind of work done o . DO NOT use retired	during most of wor	rking	16b. Kind of Busi	ness/Industry
withii iene. than	mc.	Elementary/Secondary (0-12) College (1-4or 5+)		NONE	•/		NON	E
should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, Its Modical Exarctivat roughly redified at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle,	Maiden Surname)	
Afenta Afenta rked tic ev	은	KENNETH KIRE	BY		Р	AULETTE	PATTE	RSON
and and series		19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street	and Number or R	ural Route Numbe	r, City or Town, S	tate, Zip Code)
and 2 sealth a m 27 ls		LISA KIRBY/SISTER	861				MD. 207	
Pages 1 nent of H int; If Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 ☐ Removal from State	20b. Place of Dis cemetery, ci	position (Name of rematory or other plac	ce)	Date	20c. Location - C	ity or Town, State
		4 ☐ Donation 5 ☐ Other (Specify)	CHAMBI	ERS CREMAT				ALE, MD.
permit. Departr Importa any Inju	П	21. Signature of Funeral Service Licensee		CHAMBERS	FUNERAL	HOME & C	REMATORI	UM,P.A.
482 4 4		23a. Part 1. Enter the disease, or complication, that caused the	M00091	5801 CLEV				D. 20/3/ Approximate
		shock, or heart failure. List only one cause on each line.	4		-0			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	teele	Myrocald	ia my	orcher		days
Examiner		Due to (or as a c	consequence or):	Myrocasd Comman	Atto	Mer Cons	Ô1	4000
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onse Lence of):	Colones	70.00	rosca w	<i>5</i> 0	1
ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Morbi	d obest	Ky		yeare	
be executed ician and burial-transit		resulting in death) Last Due to (or as a c	onsequence of):		V			0
cate be ohysicia the bu	dical	d						
eath certific attending p for use as	/Mec	IF FEMALE: 23c. If yes, outcome of	prognancy					
attender of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	ian/	in the past 12 months?	Fetal death	B Ctopic pregnanc	у		23d. Date Mont	
the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ne or death ;	5 ☐ Other (specify) _				
uires that the de signed by the a d be detached f	P.	Part II. Other significant conditions contributing to death but r	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
quires n sign	d by	ac Cellulités, possible	a deep i	ein-thronil	sor and	D 124	es 2 □ No 3	☐ Probably 4 ☐ Unknown
s been s	Set	pulmonary combolion by	perteurin	but the.		24a. Was a		ere autopsy findings available
The law ate has	Completed	()					med? de	or to completion of cause of ath? ⊒Yes 2 ⊠No
Physician: The la r this certificate had ral director, page 2	BeC	25. Was case referred to medical examiner?			26. Place of De	ath (Check only or	/-	2010
hysic his ce I direc		1 ☐ Yes 2 No Hospital: 1 Inpatient	2 🗆 ER/Outpat		er: 4 🗆 Nursing I	Home 5 ☐ Resid	lence 6 Other	(Specify)
ing P After t unera	on:	27. Manner of Death 1 ★Natural 5 Pending 28a. Ďate of Injury (Month, Day, Y	(ear) 28b. Time	/ Worl		28d. Describe h	ow injury occurred	3
tend feath. tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury	A1 h = (Yes 2□No	001		
or At after of Direct in by	Certification: To	4 Homicide determined 28e. Place of Injury building, etc. (Specify)	street, factory, office		City or Tow		or Rural Route Number,
		29a. Certifier 1 Certifying Physician: To the best of r	ny knowledge, de	ath occurred at the ti	me, date and place	e, and due to the	cause(s) and man	ner as stated.
e Hos n 24 h e Fur eletely	Medical	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated	kamination and/or					
To th Withir To th comp	Me	29b. Signature and title of certifier	1 100	29c. Licens			_	(Month, Day, Year)
		1 Leutop	1 1118)	02	4120		4-26	-09
		30. Name and address of person Mo completed cause of deal			*2	0	4-26 HEVERLY,	
		KAVINDEX KUSTKGI, MD	30	to the start	AL BR	4	EVERLY,	MD 20785
Stat Registra		31. Date filed (Month, Day, Year) 32. Tegistrar's	Signature	ball			,	

		_ State		artment of Health and I rtificate of Death	Mental Hygie Reg.	0000 1105
		Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physicia	an	Charles Richard Lill	or		Month April	25 2009 2:30 P ^M
/Medic		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death	<u> </u>	4c. County of Death
Examin	er	501 G Street	na namber)	Mtn. Lake Park		Garrett
		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		•
Funeral Director		569-36-4758		Months Days Hours Min.	June 16,	1922 West Virginia
		Usual Residence of Decedent	00		Julie 10,	1722 West Viiginia
and 1		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limit
f sh	ō	MD Correct	Mtn. La	ka Dark		1 X Yes 2 □ N
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evention or ust be notified at	Director	MD Garrett 10e. Street and Number	MtH. La	10f. Zip Code	10g.	. Citizen of What Country?
Mile B o				21550	111	nited States
s 23	Funeral	501 G Street	s Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (S		14. Race - American Indian,
item er de	'n	Arm	ned Forces?	f Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
s aff	by F	_ If Ye	es, Give er or Dates: WWII	1 □Yes 2X No <i>Specify:</i>		Specify: White
ural hour				dent's Usual Occupation	161	b. Kind of Business/Industry
"nal	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	kind of work done during most of wor DO NOT use retired)		, , , , , , , , , , , , , , , , , , , ,
than	ш	_	lege (1-4or 5+)	ntenance	TAT	V State Parks
t Hygic		8 17, Father's Name (First, Middle, Last)	TIGE		ne (First, Middle, Mai	
evel evel	Be	Richard Liller			Conaway	,
ould Me nark natic	မှ					Street Town Chate Tin Code's
2 sh h and ris n raun	. 3	19a. Informant's Name/Relationship (Type. Prin	· 1	ng Address (Street and Number or Ru		
and Kealth m 27 hert		Alice Elizabeth Lille		G Street, Mtn. La		c. Location - City or Town, State
les 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	t from State 205. Place of Dispo	sition (Name of natory or other place)	Date 200	2. Education - Oily of Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Even, her must be notified at once.		4 □ Donation 5 □ Other (Specify)		Cemetery 4/28	3/2009 Oa	akland, MD
mit.		21. Signature of Funeral Service Licensee	. 22	2. Name and Address of Facility David A Burdoc	k Funeral	Home, P.A.
8 9 E 8 9	1	Katherine Sw	ether	David A. Burdoc 21 N. Second St	., Oaklan	d, MD 21550
		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	that gaused the death. Do not ent	er the mode of dying, such as cardia	or respiratory arrest	t, Approximate Interval Between
Physician	ė Vi	Immediate Cause (Final	le orceacif line.	12/ijnut	Markey	Onset and Death
/Medical		disease or condition resulting in death)	ue to (or as a consequence of):	1211/00001	1000000	Decree 140
xaminer		1	ao to (or ao a consoquence o.).			
	ē	Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or injury	ile to (or as a conse vience of):			
nsit	틀	cause. Enter Underlying Cause (Disease or injury				
cate be executed ohysician and the burial-transit	Examiner	that initiated events C	Oue to (or as a consequence of):			
ilcate be executed physician and s the burial-transit	dical E	d				
phy:	ğ	d				
attending properties for use as	Ž	IF FEMALE: 23c. If v	es, outcome of pregnancy			23d. Date of delivery
atter atter for u	ä	in the past 12 months:		Ctopic pregnancy Other (specify)		Month Day Year
the d	Physician/Me		Unknown			
res that the de signed by the be detached	듄	Part II. Other significant conditions contributir	ng to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
sign sign	ğ				1 □ Yes	2 No 3 Probably 4 Unknow
w requir s been si should l	Completed					
e law has t	혈				24a. Was an autopsy	24b. Were autopsy findings availab
The page	ő				performe 1 □Yes 2 €	d? death? 1 ☐ Yes 2 ☐ No
sian: ertific ctor,	Be (25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
nysik nis ce direk		1 Yes 2 No Hospita	1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 □ DOA Other: 4 □ Nursing H	Home 5 Residence	ce 6 Other (Specify)
or Attending Physician: The law requires that the death certificate death. Director: Atter this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Ë	27. Manner of Death 28a 1 Natural 5 ☐ Pending	. Date of Injury 28b. Time o	f 28c. Injury at Work?	28d. Describe how	injury occurred
ath. r: At	aţic	2 Accident investigation		M 1 □Yes 2 □No		
Atte	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	. Place of Injury · At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, 3	et and Number or Rural Route Number, State)
safte safte at Dir	Certification: To					
To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, deal	th occurred at the time, date and place	e, and due to the cau	use(s) and manner as stated.
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page	Medical		n the basis of examination and/or in nd manner stated.	nvestigation, in my opinion, death occ	urred at the time, date	e and place, and due to the cause(s)
To th Withir To th Somp	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
->-0		+11.	Cm.	D1533	2	4/27/09
	5	30. Name and address of person who complete	ed cause of death (Item 23a) (Type	Print)	2	
	HIV	Thomas G. Johnson, 1	M.D. 311 N. 4+	h Street, Oakland	, MD 215	50
Sta	to	31 Date filed (Month Day Veer)	00 D 11 1 01		., 210.	
Penist		APR 2 9 2009	December 9. de	bartes		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, 2009 Year 8:00 P M Joseph LOEB 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgomery Montgomery General Hospital 01ney | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | No (Month 28), Year 910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F A Tabama 578-26-6532 98 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 XNo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20906 3700 International Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☐Yes 2 No 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 Tes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Commercial Real Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate Manager Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora (unknown) Morris Loeb 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 5769 Elizabethan Circle, New Market, MD 21/74 19a. Informant's Name/Relationship (Type. Print) Bernard Loeb, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 04/19/109 20c. Location - City or Town, State Garden of Remembrance Memorial Park Clarksburg, MD 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Torchinsky sherrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiomyopath Schemic disease or condition resulting in death) Due to (or as a consequence of): m Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last h_{J_i} Severe Aortic Due to (or as a consequence of) 10 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of de livery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Severe Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No Retention 24a. Was an autopsy Urinary tract 1 □Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Hipatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation

4/12/09 6 Could not be

28b. Time of Injury eve

28c. Injury at Work? 1 ☐ Yes 2 1 No

and fall Trip

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Assisted Home -

and manner stated.

3700 International Dr 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 1)65292 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince Philip Dr., Olney, MD ANUDA

State Registrar

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

2

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

Funeral

Director

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercises must be notified a

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any injury or other traur once.

Physician

/Medical

Examiner

sician and burial-transit

attending physician for use as the buria

detached

cate has been si

certificate

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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

20

funeral director,

Physician:

The law requires that the death certificate be executed

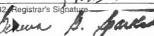
Division of Vital Records, P.O. Box 68760,

should be filed within 72 hours after death with

altimore, Maryland 21215-0036

Date filed (Month, Day, Year) 20 APR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03036 State of Maryland / Department of Health and Mental Hygiene Walter K. Long, Sr. Certificate of Death Reg. No 1. For State 2. Date of Death 1. Decedent's Name (First, Middle,Last) 0659 hrs Physician/ April 16, 2009 Med ' Examine Walter K. Long, Sr.

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Cecil Union Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months Country Maryland 09/14/1921 217-16-5106 Director 2 F 87 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 Yes 2 X No 23a or 28a-f show Rising Sun Cecil Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number United States 21911 1827 Theodore Road 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. must be Armed Forces? 1 Never Married 2 Married Specify: White Yes 2 X No -Yes 2 X No specify: If Yes, Give Year Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Manufacturing other than "1 Automobile Assembler Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Fithian William Beck Long is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1791 Theodore Road, Rising Sun, Maryland Walter K. Long, Jr. Son 20c. Location - City or Town, State If item 27 Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) April 21, Burial 2 XXCremation 3 Removal from State or other Newark. Delaware 2009 Department of Important: I Maverdale Crematory 22. Name and Address o Facility 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North east, Maryland2190 21. Signa re of Fun art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death failure. List only one cause on each line **ledical** a. Gunshot Wound of Chest Immediate Cause (Final disease ∡aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED e attending physician a for use as the burial UNPENDED 23d. Date of delivery so the Hospital or Attending Physician: The law requires that the death certificate be-23c. If yes, outcome of pregnancy Box 68760, IF FEMALE: Year Day 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death 5 Other (Specify) No 9 Unknown Yes 2 g Unknown 23e. Did tobacco use contribute to the cause of death? ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ò 24b. Were autopsy findings available 24a, Was an Completed prior to completion of cause of autopsy performed? death? 1 🗸 Yes No this certificate has ✓ Yes 2 No. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Residence 6 Nursing Home 5 Hospital: examiner? ER/Outpatient 3 V DOA Inpatient 2 1 ✔ Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year FOUND: After t 27. Manner of Death Subject shot self FOUND Yes 2 V No Natural n 24 hours after death.

se Funeral Director: A letely filled in by the fu Pending Apr 16, 2009 0620 hrs 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 1827 Theodore Road, Rising Sun, MD Could not be 3 V Suicide determined (Specify) Single Family Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 ✓ Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) Medical To the 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title April 17, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) 14262 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 04 19 2009 0821 Nannie Lanier /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 408 Lonsdale Court Bowie Prince Georges Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Yrs. Director 02/24/1923 412-14-7735 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 No Director MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Lonsdale Court 20774 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify δ 3 XWidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Erie Co. Social Welfare 4 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOe Warford Ora Childress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Wright/Daughter 408 Lonsdale Ct. Bowie, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2009 4 □Donation 5 □ Other (Specify) Fort Lincoln Cem. Brentwood MD 22. Name and Address of Facility MArshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrhythmias disease or condition resulting in death) /Medical Examiner 15 minutes Paroxysmal Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit 20 years Hypertensive Heart Disease Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Status Post Cereberal Vascular Accident Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an Cancer of Breast certificete has Osteo Arthritis 1 Yes 2 No : After this certification : After this certification : 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A
filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD25955 4/20/2009 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 Otelio Randall 2041 Georgia Ave. NW Washington DC 20060 31. Date filed (Month, Day, Year) 32. Registrar's Signature State face Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State #26 per phys., 4/21/09, eb Certificate of Death Amend item 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** LORINE April 19, 2009 8:46 LAWSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner McCready Memorial Hospital Crisfield Somerset 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Director 235-52-0361 May 1, 1936 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2V No Director Maryland Marion Station Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29247 Hudson Corner Road 21838 USA Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill h and Mental H 7 is marked oth Be John Clifford Holland <u>Bessie Elizabeth Hicks</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21817 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is r any Injury or other traur Brenda Griner (Daughter) 30410 Rehobeth Road - Marion Station, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Salisbury Crematory April 23,2009 Salisbury, Maryland 21. Signature of Funeral Service Liger e

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death ATHEROSCLEROTIC Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOVAS CULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 2**2** No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**⋉** No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 NOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours af er death To the Funeral Director completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital

the

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State Registrar

JHARAI) 31. Date filed (Month 2009

29b. Signature and title of certifier

MI) 1604 MARKET 32. Registrar's Signature

MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL,

29c. License number

00062172

POLOMORE 414

29d. Date signed (Month, Day, Year)

412012009

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MD)

			Please '	Type or Print in B State of Maryland					•	ible.		
			1 - For State Registrar			rtificate of L			Reg. No. 2	0 0	11.261	
			1. Decedent's Name (First, Middle, Las.	t)				2. Date of Dea	th	V	3. Time of Death	
	Physici /Medio		Josephine Gert	rude Matthew				April 2	22, 200	9 Year	4:00 PM	
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	Funeral Director		234-40-2990	ex	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 2:	⁷ Year) 3 1923	9. Birthp Coun West	lace (State or Foreign try) Virginia	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10	Od. Inside City Limits	
	e Mary	ctor	MD Garrett	S	wantor						1 □Yes 🗶 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examirer must be notified at once.	ral Dire	10e. Street and Number 18442 Maryland H	ighway		10f. Zip Code 21562			10g. Citizen of United		•	
980		by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ₹ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, e wh y:		
21215-0036	ithin 72 ho ne. han "natui e Medieri	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired memaker	ation furing most of work f)	ing	16b. Kind of B		lustry	
	ld be filed w ental Hygie ked other tl ic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Earl Virts				18. Mother's Name Rosa	(First, Middle, Warnic				
, Maryland	ind 2 shoul alth and M 27 Is mar er traumat	-	19a. Informant's Name/Relationship (7. Robert Arbogast/	• •	and Number or Run							
Baltimore,	Pages 1 annent of He ant: If item ury or oth		20a. Method of Disposition 1★★ urial 2 ☐ Cremation 3 ☐ urial Donation 5 ☐ Other (Specify	nemoval nom State Th 12		osition (Name of matory or other place emetery	e) 04/	/26/ ទូ	20c. Location Swanton			
Balt	permit. Departr Imports any Inj		21. Signature of Euneral Service Licens	see Bal	- 1	2. Name and Addres	. 17	oal Fune			21562	
	Physician		23a. Part 1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death one cause on each line.	. Do not en						Approximate Interval Between Onset and Death	
3	/Medical Examiner		resulting in death)	Due to (or as a consequ		10000						
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Ny kertene Due to (or as a consequ						9	leans	
68760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):							
P.O. Box 6	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the brail director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2, ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	☐ Ectopic pregnanc	у			ate of delive	ery Day Year	
	res that igned b		Part II. Other significant conditions co	11	Iting in the u	nderlying cause give	en in Part I.		\ .		ne cause of death?	
ord	w requir s been s should I	ted		14 horteneron	-			1 🗆 Y		3☐ Prob		
Division of Vital Records,	sician: The law certificate has t rector, page 2 sl	Completed by	ANemia-					24a. Was a autop perfor 1 ∐Yes	an 24b. sy med? 2 24 No	Were auto prior to con death? 1 □Yes	psy findings available mpletion of cause of 2 □No	
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat					
of	Phys this ral dir	: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie		4 LI Nursing Ho	ome 5 Resid			y)	
sion	Ing Afte	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	Injury	M 1 □	yat (? Yes 2 □No	Zou. Describe ii	——			
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	eet, factory, office		28f. Location (S City or Tow	Street and Num n, State)	ber or Rura	il Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (ysician: To the best of my knowiner: On the basis of examination and manner stated.								
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)	

21502

-	Was case examiner? 1 ☐ Yes		to medical
7.	Manner of	Death	

manegn en Nelsay MD 29c. License number D0065518

GOI KELLY Rd -

29d. Date signed (Month, Day, Year) 4/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIAYN MK NELSON mD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Combessand Md

State Registrar

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			For State Registrar	State of Ma	aryland	-	artmen rtificat			and M		giene Reg. No.	2005	1420		
			1. Decedent's Name (First, Middle, Last)								2. Date of De			3. Time of Death		
	Physici		Pa	mela Anneti	te Mun	uni					Month April	Day 16	Year 2009	10:35 am		
	/Medio		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death			County of Death	1		
	LAGIIII	iei	Holy Cross	Hospital			Silver Spring						Monte	gomery		
	Funeral		5. Social Security Number 6. Se	2x 7. Ag	e (In yrs. la	st birthday)	If Under	1 Year	If Under 2	24 Hrs.	th 9. Birthplace (State or Foreign Country)					
	Director		578-76-9623	□M 2 ⊠ F	58	Yrs.	Months	Days	Hours	Min.	March 2					
	p .		Usual Residence of Decedent													
	rylar	_	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits		
	Ba-f	cto	Maryland Montg	omery					Silve	er Spi	ring			1 ☐ Yes 2 🗷 No		
	⊕ th	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ıntry?		
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, if a Medical Exavitrat must be notified at	ra	317 Woonsock	et Lane					2090				Barbado	os		
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Deced	dent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 			
36	afte or it	y Fi	1 Never Married 2 Married	1 ☐ Yes 2 🗷 I If Yes, Give	No		1 □Yes		Specify:				Specify:			
8	ural	d by	3 Widowed 4 Divorced	Year or Dates:										B1ack		
5	"nat	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		(Give	dent's Usua kind of wor	rk done a	luring most	t of workii	ng	16b. Kin	d of Business/I	ndustry		
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2	Hygie Hygie Ther I		17, Father's Name (First, Middle, Last)	5+				orrect		r's Name	(First, Middle,			ites		
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Ë	should be filed within and Mental Hygiene. is marked other than aumatic event, It with	유		enderson Art	tnur	405 14-75	4 . 1	(2)			rie Eurit		Town, State, Z	En Onda)		
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (7				•	,						•		
	1 and Health em 27 ither to	. 9	Stephen T. Mumuni - 20a. Method of Disposition	Husband	20h Pia						er Spring	,,	yland 209			
Baltimore,	Pages nent of int: If its iry or o		1 ☐ Burial 2 🗷 Cremation 3 🗍			ace of Dispo metery, crer			i	_						
Ē	it. P.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	$\overline{}$	Fort	Linco	In Cres				L/2009	Brent	twood, Ma	ryland		
Ba	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Once.		Vac A.	Vence	<u>t</u>	·	Hines-l	Rinal	di Fune	eral l	Home, Inc enue, Sil	c. Lver S	pring, M	aryland 20904		
			23a. Part 1. Enter the discase, or comp shock, or heart List only of	lications that caused ne cause on each li	d the death. ne.	Do not ent	er the mod	de of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate se (Final disease condition resulting in death)	и.	_	nary A	rrest									
4	/Medical Examiner		Toolsting in doctry	Due to (or as												
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5	ted nsit	i i	if any, leading to immediate cause. Enter oridenying Cause (Disease or injury													
	execu al-trai	Examiner	that initiated events resulting in death) Last	c. Acute Colitis Due to (or as a consequence of):												
8760,	icate be executed physician and the burial-transit	dical E											i			
687	ficate g phy: s the	edic		d										_		
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of del	verv		
Ď	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ■No	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic p ☐ Other <i>(sp</i>		/				Month	Day Year		
P.0	at the di	hys	9 Unknown	9 ☐ Unknown												
	es tha igned be det		Part II. Other significant conditions co	entributing to death b	ut not resul	ting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?		
Vital Records,	E S	Completed by	Scleroderma								1 🗆 '	Yes 2□	No 3 Pr	obably 4 🔀 Unknown		
ပ္က	law rec as bee 2 shou	olet	Systemic Lupus E	rythematosu	s						24a. Was	an	24b. Were au	topsy findings available		
ž	he hige	E									autoj perfo 1 □Yes	rmed?	death?	completion of cause of 2 □ No		
ta		a)	25. Was case referred to medical						26. Place	of Death	(Check only o		I 🗆 ies	2 🗆 140		
>	ysic s ce direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🗷 Inpatio	ent 2 🗆 E	R/Outpatie	nt 3 🗆 DC	Othe	er: 4 🗆 Nu	ırsing Ho	me 5 ☐ Resi	dence 6	☐Other (Spec	cify)		
J Of	ding Phy h. After thi funeral (27. Manner of Death	28a. Date of Inju	iry iv Year)	28b. Time o Injury	f 2	28c. Injun Work	y at		28d. Describe	how injury	occurred			
. <u>ō</u>	Attending r death. ector: After by the fune	atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,	,,	М		Yes 2 □ i	No						
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	ne, farm, str	eet, factory	, office			28f. Location (Number or Ru	ral Route Number,		
	spital or ours afte neral Dir filled in			<u> </u>												
	Fur h	Medical		vslclan: To the best iner: On the basis of and manner st	of examinati											
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier	1 and manner st	ateu.		290	c. License	e number			29d. Date	signed (Montl	n, Day, Year)		
	10		= lot	toin		MI)		006506	9			pril 16,			
			30. Name and address of gerson who	ompleted cause of	leath (Item	23a) (Tune	Print)		00000				Arri 10,	2007		
			Mario mile made occ or project if will to	PIOCOG VAGOU VI (

State Registrar

Lemma Sirak, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year)

APR 20 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / L Registrar	Certificate of Dea		Reg.	ne 009	14266
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death
	/Medic		Joseph McLaughlin			pril 13	4c. County of Death	10:10 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Local	ation of Death			oorgo! a
. 46	Funeral		Cherry Lane Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Jnder 24 Hrs. 8. I	Date of Birth (Month, Day, Ye	Prince G	place (State or Foreign
	Director		247-84-5240 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Yrs. Months Days Ho		c 19, 1		h Carolina
	put		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			1	0d. Inside City Limits
	faryla fshor ed at	o		Burnie				1 X Yes 2 □ No
	the N 28a- notifi	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	h with 23a ol st be	al D	6662 Roberts Court #88C	21061			United Sta	ites
9500-612	72 hours after death with the Maryland "natural", or items 23a or 28a-f show "fleal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 □ Yes 2 ▼ No Spe	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- in, etc.)		^{can Indian,} ^{etc.} African American
Ş	2 hou	ted		Decedent's Usual Occupation	a mast of working	16b	b. Kind of Business/In	dustry
7		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during life. DO NOT use retired)			Government	-
7	e filed within al Hygiene. other than '		/ years He		Mother's Name (Fi			
and	be d d) Be		10. 1		ha Yate		
aryı	2 should be f n and Mental I Is marked of raumatic eve	ဍ	Joseph McLaughlin, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b	. Mailing Address (Street and N				Code)
Ĕ	1 and 2 thealth a em 27 is other trau			6662 Roberts Co	ourt 88C	Glen Bu	rnie, MD 2	1061
e,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of cemeter 20b. Place of cemeter	f Disposition (Name of ry, crematory or other place)	Date	200	. Location - City or To	wn, State
Ĕ	Pages ment of ant; If its ury or o			incoln Cemeter	ry April	24, 200	9 Brentwo	ood, MD
Бапт	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee	22. Name and Address of F	DLEV		neral Home	-
			23a. Pan 1. Enter the disease, or complications that caused the death. Do shock or heart failure. List only one cause on each line.	not enter the mode of dying, suc	uch as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician		resulting in death)	from Cerebrova	ascular A	ccident		
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Ď,	e exer ian ar irial-tr	Ex	resulting in death) Last	of):				
58/60,	ificate be executed g physician and as the burial-transit	edical	d					
×	death certific le attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv	rery Day Year
	0 0 0	ıysic	1 Yes 2 No 9 Unknown	3 □ Other (specify)				
ρ, J	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in f	Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ğ	quires	ed by	Diabetes Mellitus			1 ☐ Yes	2 No 3 Pro	bably 4∑ Unknown
	e law re has bee je 2 sho	Completed	Decubitus Ulcers			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
r	The ate h	MO(performer 1 □ Yes 2 2	d? death?]No 1 ☐ Yes	•
VITal	ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?		Place of Death (C	heck only one)		
0	Phys this al dir	٦.	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou 27. Manner of Death 28a. Date of Injury 28b.			5 Residenc	e 6 □Other (Speci	(fy)
5	ding h. After funer	tion		Time of 28c, Injury at 1		. Describe now i	injury occurred	
UIVISION	Atten r deat sctor: by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa			Location (Stree	et and Number or Run	al Route Number,
S	al or safter	Serti	4 ☐ Homicide determined building, etc. '(Specify)			City or Town, S	state)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License num	mber		Date signed (Month,	
	3		▶ of Kellung	D43351		Ap	ril 17, 20	109
	61		30. Name and address of person who completed cause of death (Item 23a)		,			207/6
		.	Dr. Ikechi Fred Okwara, M.D. 6201	Greenbelt Roa	ad #U15 C	ollege_	Park, MD 2	20740
	Sta Registr		31. Date filed (Month, Pay Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-02957 State of Maryland / Department of Health and Mental Hygiene Michael Lorenzo Murray Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day April 13, 2009 Physician/ 1952 hrs Murray Michael Lorenzo Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) Prince George's Fort Washington Fort Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min Months Days Country) July 20, 1960 Yrs Director 48 2 F 1 X M 577-88-1302 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Waldorf Charles s 23a or 28a-f show : notified at once. Maryland 10g. Citizen of What Country? hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number United States 20602-2691 3443 Hyacinth Place Unit D 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. African Armed Forces 1 X Never Married Married Specify: American Yes 2 X No Yes 2 X No specify: Itimore, MD 21215-0036

it Pages I and 2 should be filed within 72 hours after do
tine 10 Health and Montal Hygiene.

retant: If item 27 is marked other than "natural", or
y or other traumatic event, the Medical Examiner m If Yes, Give Year Widowed Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DD NDT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private Fork Lift Operator 1 year 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn K. Murray Louis Price Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3008 Rosemist Way Forestville, MD 20747 Linette A. Branch - Sister 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) timore, 2009 Landover, MD Removal from State 1 X Burial 2 Cremation 3 Harmony Memorial Park April 22, Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Savio NE Washington. Benning Road Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Physician ajlure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED signed by the attending physician if be detached for use as the burial -The law requires that the death certificate be of 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of peen autopsy death? performed? has 2 No 1 🗸 Yes ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, Division of Vital Other: Be Nursing Home 5 Residence 6 examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA ٩ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury Subject driver of vehicle in vehicular accident 27. Manner of Death Apr 13, 2009 1908 hrs Yes 2 V No Certification Natural Pending 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Rt. 210 and Wilson Bridge Drive, Fort Washington , MD Could not be 3 Suicide determined (Specify) Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Theodore M. King, Jr., MD.

Assistant Medical Examiner 32. Registrar's Signature

who completed Juse of death (Item 23a)

ORIGINAL

OCME

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 14, 2009

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi P.0. Division of Vital Records, filled in by completely

State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/11/2009 RUTH MURRELL 10:25 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charles County Nursing & Rehab. La Plata Charles Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 241-44-6657 9/22/1919 89 Gainesville, NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item s 23 a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Yes 2 □ No Maryland Prince George's Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5611 Gloria Drive 20746 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√€ No Specify: þ Specify: Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important; If item 27 is marked ott any injury or other traumatic ever anse. ္ရ John Thomas Forbes Malida Heidelberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Murrell / Son 5611 Gloria Drive Camp Springs, Maryland 20746 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 4/18/2009 | Clinton, maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA DAYS disease or condition resulting in death) Due to (or as a consequence of): INTRACEREBRAL HEMMORAGE WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 2 No 2 🗆 No 1 ∐ Yes 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🛚 Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sindleum D 0061614 4/17/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Post Office Road Suite 101 Waldorf, Maryland 20602 Sindhwani, MD Ravi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

To the Hospital within 24 hours a To the Funeral D

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

"natural", or items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exameratone.

Physician

/Medical

Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Affer this certificate has been signed by the a funeral director, page 2 should be detached to

P.O. Box 68760,

of Vital Records,

Division

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

William B. Kerns

or other traumatic event, the Medical Examiner must be notified at

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month pro SOUN Facility Name (If not institution, give street and number Social Security Number 7. Age (In yrs, last birthday) Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Days Hours 1 M 2 □ F VILNO Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1ÆYes 2 ☐ No Da IMORP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No. Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tanager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra Mall Dr. 650 E. Vista Ridge Lewisville_TX 75067 20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory 20a. Method of Disposition Date 2005 1 ☐ Burial 2 ☐ Cremation OVER, DE 4 Donation 5 ☐ Other (Specify) Matthews Commerce St. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ewi disease or condition resulting in death) Due to (or as a consequence of): se of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24a. Was an

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed

After this

within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

Injury or other

Funeral Director

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Completed

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burial-tran attending physician and for use as the burial-trar

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due (or as a consequence of): c. Salvanold Backeremin Due to (or as a consequence of): d. Angrothwwstv Muchymycosis	2 M
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day
γP	Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco u	use contribute to the caus

Be 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 ☐ No 1 ☐ Yes 2 No 1 🗆 Yes

25. Was case referred to medical examiner? 1 Yes 2 1No 27. Manner of Death

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Natural 5 Pending investigation 2 Accident Could not be determined 3 Suicide 4 Homicide

28c. Injury at Work? 1 □Yes 2 □No

29a. Certifier

Certification: To

Medical

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Typa, Print)

State Registrar

31. Date filed (Month, Day, Year. Registrar's Signature

			For State	State	of Marylan		artment rtificate			nd Me		giene Reg. No		Q	14271
٧	1 2 7	-4	Registrar Decedent's Name (First, Middle,	Last)			imoato	0, 0		2	Date of Dea				3. Time of Death
	Physicia Medic/			eatrice (e Newt					pri1	23	200	9	1923 P ^M
	Examin	er	4a. Facility Name (If not institution, Union Hospital	give street and nu	ımber)		4b. City, To	own, or L ton	ocation of	Death		40	Cecil		
_	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 24	4 Hrs. 8 Min.	. Date of Birt (Month, Da	h v. Year	9.1		ce (State or Foreign
	Director		219-10-2157	1□M 2∏ F	83	Yrs.	MOITHIS	Days	Tiodis	J	JAN 2,	192	6		yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	I. Inside City Limits
	a-f sh	ctor	Maryland Cecil		I	E1kton									1 ☐ Yes 2 X No
	vith the	Funeral Director	10e. Street and Number				10f. Zip 0					3	tizen of What		
	ns 23¢	eral	1204 Appleton	12. Was Dec	cedent Ever in U.	.S. 13.		921 int of Hisp	panic Origi	in? (Speci	fy Yes or No can, etc.)		United 14. Race - A	mericar	Indian,
>	or Iter	Fur	1 ☐ Never Married 2 ☐ Marrie	Armed F ed 1 ☐ Yes If Yes, G	orces? 2 ∏ No ive		If Yes, specif 1 ☐ Yes 2		, Mexican, Specify:	Puerto Ri	can, etc.)		Black, W Specify:	hite, et	c.
3	hours tural", al Exa	d by	3 ₩ Widowed 4 Divorced	Year or I	Dates:		dent's Usual					16b. k	(ind of Busine	Whit	
2	nin 72 In "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed,	(1-4or 5+)	(Give	kind of work DO NOT use	done du	ring most (of working	,		County		
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2	t be fill ntal H ed oth	Be	17. Father's Name (First, Middle, I Charles Raymone		. 1					,	First, Middle, 1i11er	Maidei	n Surname)		
3	should nd Me mark mark	To	19a. Informant's Name/Relationsh		<u></u>	19b. Maili	ng Address (-	er, City	or Town, Stat	e, Zip C	Code)
Ž	and 2 ealth a n 27 is		Portia A. Loom	is/Daught					t Roa		Ikton.				
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merfall Hyglene. Important: If item 37 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		Ctata	Place of Dispo cemetery, cre 1pin M	matory or otl	e of ner place,) A ₁	$\mathtt{pri1}^{^{Dat}}$			ocation - City		
	artmer ortant injury		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Me	morial	Park	Address	2(of Facility	009	-1 7		E1kton	, M.	D
0	permi Depa Impo any it		Donal.	8. Hi	Cash	1	os W.	Stoc	kton	Stre	als, E	Lkto	on, MD	219	921
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the deat each line.			of dying,	, such as c	eardiac or i	respiratory a	rrest,			Approximate nterval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to	(or as a conseq			-						Τ΄	
Ē		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	juence of):									
4	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С											
2000	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last	Due to	(or as a conseq	juence of):									
000	ficate I physics the k	edical		d											
400	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live	utcome pf pregn birth 2 Feta gnant at time of c	aldeath 3	⊒Ectopic pre ⊒ Other <i>(spe</i>						23d. Date of Month		y Day Year
į	at the c by the tachec	hysi	9 Unknown	9□Unk							T		-		
ָה ה	res tha signed be de	b	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	ınderlying ca	use giver	n in Part I.					,	cause of death?
COLCO.	v requi	eted									24a. Was				sy findings available
ב ב	The lav e has age 2	Completed									auto		prior	to com h?	pletion of cause of
ב	ertifical ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death ((Check only o		- 10	103 2	
5	Physic this ce	٦ 2	1 ☐ Yes 2 ☐ No 27. Manaer of Death		Inpatient 2 =	ER/Outpatie			4 □ Nur		e 5□ Resi 3d. Describe		6 □Other (Specify)	
5	ding I h. After funer	tion:	1 Natural 5 Pending 2 Accident investig	g (Mo	nth, Day Year)	Injury	M	Bc. Injury Work? 1 □ Y	ai es 2 □ N		od. Describe	HOW HIJ	ary occurred		
	Atten er deat rector by the	Certification:	3 Suicide 6 Could r 4 Homicide determ		e of injury - At h	ome, farm, st	reet, factory,	office		28	Bf. Location (City or To	Street a	and Number o	r Rural	Route Number,
2	urs after or arter or		29a. Certifier 1 Certifyin	g Physician: To th			th appropriate	at the a time	o dato and	d plane or				r ac eta	stad
	e Hosp 24 ho e Fune letely f	Medical										date a	nd place, and	due to	the cause(s)
.	To the within To the comp	Me	29b. Signature and title of certifier 30. Name and address of person S. S. S. A. A. A. W. 31. Date filed (Month, Day, Year)	BUS MD			29c.	License	number 2332	2		29d. D	ate signed (M		
	la		30. Name and address of person	who completed car	use of death (Iter	m 23a) (Type	, Print)	=eb	Ton l	ND2	1921				
	Ų Sta	te	S.S Sa didev 31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	· / C								
	Registr	rar	MAY 0 4 2009	Geneur	E A.	park	"								
DН	MH 17 Rev 1/2	001				•									

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Patricia Louise Odintz 14 2009 11:40 a M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11400 Strand Drive, #305 N. Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🕮 F Director 072-38-2256 63 February 03,1946 New York Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Exertings the notified at 1 x Yes 2 □ No Director Maryland Montgomery N. Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Executant to any once. 11400 Strand Drive, #305 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No à Specify: 3 Widowed 4 X Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Defense Contracting **Business Person** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Irene Kirschman Alvin Aaron Odintz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua David Odintz - Son 6210 Hollins Drive, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 04/19/2009 Clarksburg, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -0, drovally Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 2 □ No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 **V** No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation To the nosperation within 24 hours after death.

To the Funeral Director; After the fund in by the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the funding the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 14273 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 27, 2009 Year **Physician** 8:35 AM [™] Harold Paul O'Brien /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Care & Rehabilitation Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F Maryland 89 216-01-8826 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner roust be notified at YXYes 2 □ No Director Maryland Frederick Frederick permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Inmortant: If item 27 is marked other than "natural"; or items 23a or 28a-f any injury or other traumatic event, the Modical Examinat must be recently once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21701 471 Carrollton Drive Completed by Funeral 12. Was Decedent Ever in U.S. 1
Armed Forces?
XXYes 2 No
1796s, Give 1941–1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent/Adjuster 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Tharp Patrick O'Brien ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Frederick Road, Catonsville, MD 21228 Joan K. O'Brien, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Apr. 30, 2009 Frederick, MD 4 Donation 5 Dother (Specify) 21. Signator of Pageral Service Lice *Keenev Agna Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DISEASE Immediate Cause (Final **Physician** OBSTRUCTIVE カロソ S CHRONIC PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de ath
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 -No 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Matural 5 | Pending investigation 1 □Yes 2 □No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9 MI April 27, 2009 20061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

TOLI HOUSE - HY

			For State		State of M	•		artment of F rtificate of	lealth and l Death	Mental H	ygier Reg. 1	- / 1111	3 1	4274
		•	Registrar 1. Decedent's Name	e (First, Middle,	Last)					2. Date of D	eath		3.1	ime of Death
	Physici		Leonard	Edward	Pasek					Month April	15	oay 2009 Year	5	:20 A M
and is	/Medio Examin				give street and number)			4b. City, Town, o	r Location of Death			4c. County of Dea		
- tor			Wilson H	ealth C	are Center			Gaither	_			Montgom	ery	
	Funeral		5. Social Security N			e (In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Da <i>y, Yea</i>	9. Bi	rthplace (State or Foreign
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	and w		Usual Residence of	10b. County		10c. City, Town	or Lo	ocation					10d. In	side City Limits
	//aryi	ō	MD	Montgo	m o r 37	Gaithe							1	XYes 2 □ No
	the N	rect	10e. Street and Nu		mer y	Gazene		10f. Zip Code			10g.	Citizen of What C	ountry?	
	3a or	Ö	403 Russ	e11 Ave	nue #805			20877	7		U	nited St	ates	
	death ms 2	Funeral Director	11. Marital Status		12. Was Decedent		13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or N	lo-	14. Race - Am		dian,
9	or ite		1 Never Marr	ied 2 🔀 Marrie	Armed Forces? 1 Tyes 2 Tyes If Yes, Give			in Yes, specify Cub. 1 □ Yes 2 🕱 No	Specify:	o rican, etc.)		Black, Whi		
903	filed within 72 hours after death with the Maryland Hyglene. uther than "natural", or items 23a or 28a-f show ont, the Medical Exercitate must be notified at	d by	3 Widowed	4 Divorced	Year or Dates:			177				Specify: Wh		
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Maryland 21215-0036	ld be lental ked c	To Be	Edward D. Pasek Ida Marie Maton									k		
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ž	alth alth a		Rosemary	Pasek	(Spouse)	40	3	Russell A	Avenue #8	05 Gait	ther	sburg, N	\mathbf{D} . 2	0877
J. C	of He		20a. Method of Dis		По	20b. Place of E	Dispo ; crei	osition (Name of matory or other pla	me) Apr	Pale 17	20c.	Location - City o	r Town, S	tate
<u>E</u>	Page ment ant: It			5 ☐ Other (Spe	3 ☐ Removal from State ecify)			tan Crema		09	A1	exandria	a, Vi	rginia.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfort Exp. it act must be nortified at once.		21. Signature of Fu	ineral Service U	censes		2:	O Fast Do	^{ess of Facility} De eer Park	Vol Fu	nera Gait	l Home	z, MI	. 20877
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87	physi the t	edical			d									
× 6	eath certifi attending for use as	/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy						23d. Date of d	olivory	
Вох	atter for u	Physician/M	in the past 12	months?	1 Live birth	2 ☐ Fetal death		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	СУ			Month	Day	Year
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ğ	w require s been sig should b									1 🗆	Yes	2 No 3 1	Probably	4 Unknown
of Vital Records,	aw re as ber 2 sho	Completed								24a. Wa		24b. Were a	autopsy fi	ndings available ion of cause of
ĕ	: The law cate has page 2 s	E O								per 1 🗆 Yes	opsy formed 2	2 death?	s 2 🗆	
ita	stclan: The certificate irector, page	Be C	25. Was case refer examiner?	red to medical					26. Place of Dea					
>	hysicathis ce	70	1 Yes 2	No	Hospital: 1 ☐ Inpati	ent 2 ER/Outp	oatie	nt 3□ DOA Oth	ner: 4 🖪 Nursing H	lome 5 ☐ Re	sidence	6 ☐ Other (Sp	ecify)	
2	ding Ph h. After th funeral	ü.	27. Manner of Deat	th 5 Pending	28a. Date of Inji (Month, Da	ury 28b. Ti ay, Year) Inj	me o jury	Wor		28d. Describe	e how ir	njury occurred		
Sio	tendi leath. tor: / the fu	cati	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could no	ot be				Yes 2 □No	201 1 1	15.			
Division	after death after death Director:	Certification:	4 ☐ Homicide	determin	20e. Place of in	ury - At home, farr c. (Specify)	n, sti	reet, factory, office		City or T	(Street own, St	t and Number or I tate)	Rural Rou	te Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)		xaminer: On the basis and manner st	of examination and								
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	(30. Name and add	ess of person y	no completed cause of	death (Item 23a) (T	ype,	Print	1 1			11 1		2009 MI
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:27 DM Peter S. Purrell 04 8 -2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Coastal Hospice at the Lake Salisbury If Under 1 Year | If Under 24 Firs. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign NY Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) 944 **Funeral** Days Hours Min. 64 094-34-3914 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Wellon Event in a unit by putility at 1 ☐ Yes 2 ☑ No Director Ocean Pines MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21811 Funeral 22 Bearberry Road . Was Decedent Ever in U.S. Armed Forces? 1 Y Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Vietnam Specify Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tel. Com. Consultant Verizon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Constance Steineger</u> Edmund Purrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Bearberry Road Ocean Pines, MD 21811 Lyndell Purrell-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-20-2009 Frankford, DE Cape Henlopen Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 Williams Street Berlin, MD 21811 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. art / Enter the disease, or complications that caused a sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRTASTA LUNG PARCINOWA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him ellat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Veal in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 MANo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the death certificate be executed P.O. Box 68760. Division of Vital Records, Hospital or Attending P 24 hours after death. Funeral Director: After t To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

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State

Registrar

Medical

29a. Certifier

29c. License number 00058410

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and manner stated.

P.O BUP 1733 Stars Buy up 21802

6 Huggin 32. Pegistrar's Signature 31. Date filed (Month, Day, Year)

APR 20

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 26,2009 APRIL SYLVIA REBECCA JOY PANKAKE 5:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLOTTE HALL VETS.HOME CHARLOTTE HALL ST.MARY'S If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 10-27-1925 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 □ F 579-24-4482 83 Yrs. MD. Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD. CHARLES WALDORF 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 3346 OLD WASHINGTON ROAD 20602 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. HOMEMAKER OWN HOME 12 If item 27 is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLAUDE LEROY DeMARR IRENE ELIZABETH DeMARR ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOHN PANKAKE-SON 36965 TANYARD DR. MECHANICSVILLE, MD. 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDEN 4-29-09 WALDORF, MD. 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee M00479 LA PLATA, MD. 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DISEASE ALZHEIMERS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ESSENTIAL HYPERTENSION 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has li rector, page 2 s perform 2 🗆 No 1 □ Yes 242 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes & No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D67788 4.27.2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODA Charlote RAO EENA 32. Registrar's Si State

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	-	N M) _ Im	7			O.C	.M.E.			April 28, 2	2009	
		30. Name and address of pe	erson who complete	d cause of death	(Item 23a)					1001			
		Donna M. Vincent	i, MD Assista	ant Medical E	xaminer			t, Baltimor	e, MD 2	1201			
Pogi	Stat	190 A V 111	4 2009	32 Registrar's Sig	gnature .	arked	,	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of De 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** APRIL 17, 10:20 MARY ANN RUSSELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON If Under 1 Year SOUTHERN MARYLAND HOSPITAL If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🛛 F Yrs. 1/23/1935 Greenville, VA Director 579-50-7385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County event, the Medical Examiner must be notified at X☐Yes 2 ☐ No Directo Maryland Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number filed within 72 hours after death with United States 20735 11700 Lauer Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 If Yes, Give 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than NIH Clerk 12 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Be Lauer Jones ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) \$112 Daniel Drive District Heights, Maryland 20747 item 27 i Irish William-Garner / Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2009 Landover, Maryland 4 □ Donation 5 □ Other (Specify) Harmony Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. well olass 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Eigher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): heurt Discuss Examiner Archirisclewic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be execute and burial-tra Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
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2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. al or Attend s after death il Director: / the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only

State

Registrar

29b. Signature and title of certifie

one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. II. A. I. TANNER Mn II. 101 L. W. 11701 Grungton Road Fort Washington 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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eulcai Examina		a. Facility Name (if not institution		umber)		4	b. City, Tow	n, or Lo	cation of I	Death		4c. County of		
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after o	<u>-</u>		orced If Yes, Give Ye or Dates:				Yes 2 X			nd of work d	one	Specify: 16b. Kind of Bus	siness/Ind	
natura		15. Decedent's Education (Spe			ed) 16	a. Deceden during m	t's Usual Ud ost of worki	ng life. I	DO NOT u	ind of work d ise retired)	one	TOD. Tand or Doc		,
36 thin 72 h te. than "r	ompleted	Elementary/Secondary (0-12)		(1-4 or 5+)			Homer	1			ĺ	Uor	own	home
within ien the	ĔĹ	12 17. Father's Name (First, Middle	2				пошет	1ake	8. Mother's	Name (First	, Middle, M	aiden Surname)	OWII	Hone
filed with Hygien of other t, the Me	<u>ا</u> ا								Indi	th Ric	hards			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than mered other than	e l	Thomas James St 19a. Informant's Name/Relations	n1th ship (Type, Print)		- 1	19b. Mailing	g Address	(Street	and Numb	ber or Rural	Route Num	per, City or Town	n, State, Z	Zip Code)
Imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	-1	Stephen Reynol		and		213 V	Joodpo	oint	Ave	nue. E	lagers	town. M	d. 2	1740
and 2 and 2 fealth item 2	ŀ	20a, Method of Disposition		1	20b. Pla	ce of Dispos matory or ot	sition (Name	of cem	netery,	Dat	е	20c. Location -	City or To	own, State
OFF ges 1 it of 1 i: If i		1 Burial 2 X Crematio		from State		erstow		mat	ory	4/27/	09	Hagers	town	, Maryland
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee				Name and A					Funeral		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic.	- Î	160A711	2.0.			41.	5 E. T	Vils	on B	lvd. H	lagers	stown, M	ld. 2	
Physician	\dashv	23a. Part I. Enter the disease, of	r complications that	t caused the	death. D	o not enter	the mode of	dying,	such as ca	ardiac or res	oiratory arre	est, shock, or he	art	Approximate Interval Between Onset and
/M. dical	4	failure. List only one cause Immediate Cause (Final disease	e a Cardi	ac ar	rythi	nia								Death
taminer		or condition resulting in death)	Due to (or as	s a consequ	ence of):									
		Sequentially list conditions,	b. Heart Due to (or as											
	<u>i</u>	if any, leading to immediate cause. Enter Underlying Code	C.											
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Box 68760, e death certificate be the attending physic cd for use as the but	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in	Ale -	es, outcome re birth	of pregna		etal death	3	Ectopio	c pregnancy		Month		ay Year
certif	ciar	past 12 months?		egnant at tim	ne of deat		Other (Spec	ify)				A		
30X death ne atte	isi	1 Yes 2 No 9 🗸 U	0 0	known							00 0111		tributo to	the cause of death?
O. If the 11 by the tachee		Part II. Other significant cond	ltions contributin	g to death b	ut not res	sulting in the	underlying	cause	given in Pa	art I.				pably 4 V Unknown
P. res that signed be de	d by									3				topsy findings available
rds, requirements of the peen should	Completed										24a. Was auto	psy	prior to c	completion of cause of
e law e has ge 2 sl	mp	Y										ormed? 2 No	death? 1 ✓ Ye	es 2 No
Re ifficat or, pag		25. Was case referred to medi	cal					26.Plac		(Check only	one)			
'ital sician is ceri	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2	ER/Outpatie	nt 3 D	OA	Other ₄	Nursing H	ome 5	Residence 6	✓ Other	r: Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	\vdash	27. Manner of Death	28a. D	ate of Injury		28b. Time o	f Injury	28c. Inju	iry at Wor	k? 28	d. Describe	how injury occu	irred	
onding	tion		ending				Į	-	Yes 2					
ivisic I or Atte after des Directo	fica		vestigation 28e. F	Place of Inju	ry - At ho	me, farm, st	reet, factory	, office	building, e	etc. 28	f. Location or Town,		iber or Ru	ural Route Number, City
Div	Certification:	4 Homicide de	termined (Spec	-										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only 1 Certifying	Physician: To the xaminer:On the ba	best of my	knowledg	e, death occ	curred at the	e time, o	date and p	lace, and du	e to the cau	ise(s) and mann e and place, and	er as stat due to th	ted. ne cause(s)
To the within To the comple	Medical	one) 2 Medical E	xaminer: On the ba and mann	isis of exami ner stated.	nation ar	id/or investi					- Inne, aut			onth, Day, Year)
F % F 8	ž	29b. Signature and title of cert	ifier			,	29		se numbe	oc. Oc.	E	April 27,		
		Theoder W	U. Kin	X II	2.11	m.		<u> </u>		001/1				
_		30: Name and address of pers	on who completed	dause of de	ath (Item	23a)	111 D	enn C	treet R	altimore,	MD 2120)1		
		Theodore M. King,		istant Me										
S Regis	tate	- W 13 V	0 4 2009 3	Lever	Joignall	B. A	barka							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2^{Day} Richard Patrick Roberts 2009 April 8:25 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 466 Carrollton Drive Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 04/07/1936 Birthplace (State or Foreign Country) Funeral 185-26-9082 73 Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Director Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 466 Carrollton Drive 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Aryes 2 □ No If Yes, Give Year or Dates: 55-59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2X Married "natural", or i 1 ☐ Yes 2 👿 No þ Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) supervisor/mailing room insurance is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Emlen Roberts Kathryn Priest ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Lois Roberts / wife 466 Carrollton Dr., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 4/30/2009 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home gayrelle the MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory /Medical Due to (or as a consequence o): Examiner inte Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-1 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ď in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 1 ∐Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, has certificate this

hours after

within 72

Baltimore, Maryland 21215-0036

signed by the a d be detached for sompletely filled in by the funeral director, within 24 hours after deat To the Funeral Director:

> State Registrar

29a. Certifier

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Mr

31. Date filed (Month, Day, Year)

Thomas Johnson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Kanan

29d. Date signed (Month, Day, Year)

			_ State	State of Mary		rtment of Hea tificate of De				14201
			Registrar 1. Decedent's Name (First, Middle, Last)			incate of be		2. Date of Deat	ag. No.	3. Time of Death
1	Physicia	an		s 4.1-				Month April	Day Year 23 2009	12:30 P ^M
1	/Medic		Edith Pearl Sm 4a. Facility Name (If not institution, give s	treet and number)	1	4b. City, Town, or Loc		Thrir_	4c. County of Dea	
	Examin	er	Dennett Road Manor		OTIE	0akland			Garrett	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year If		8. Date of Birth		thplace (State or Foreign ountry)
	Funeral Director		213-24-5680	M 2X)F 102	Yrs.	Months Days H	Hours Min.	(Month, Day, Aug. 1	1 1906 We	st Virginia
	ס		Usual Residence of Decedent							10d. Inside City Limits
	nylan thow		10a. State 10b. County	10	c. City, Town or Lo	cation				1 ☐ Yes 2 🏋 No
	Se-1 s	cto	WV Mineral		Elk Garde					
	hours efter death with the Maryland tural, or Items 23a or 28e-1 show al Exatrainer must be motified at	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath w	ē	Rt. 1, Box 26			26717	-i- O-i-i-2 (C		United Sta	
	tems	Funeral	11. Maritar Otatas	2. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, N	Mexican, Puerto P	Rican, etc.)	Black, Whi	
36	s efte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2k No If Yes, Give Year or Dates:		I□Yes 2X∑No S	Specify:		Specify:	nite
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Maryland 21215-0036	be filed within 72 ho ital Hygiene. d other than "natur event, Itie Medical	BeC	17. Father's Name (First, Middle, Last)			18	. Mother's Name	(First, Middle,	Maiden Surname)	
an	lid be lenta rked	To B	James Sollars				Betty M	urphy		
ary	2 should be filed within and Mental Hygiene. I is marked other than "raumatic event, the Mar		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street and	Number or Rural	Route Number	, City or Town, State,	Zip Code)
Ž	elth a		Charles Smith, Son	ı	Rt.	1, Box 30,	, Elk Ga	rden, W		
ē,	ges 1 end 2 should it of Heelth and Men if Item 27 is marke or other traumatic		20a. Method of Disposition		20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Da	ate	20c. Location - City of	r Town, State
Baltimore,	permit. Pages 1 end 2. Department of Heelth ar Important: if Item 27 is any injury or other traigner.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☑ Donation 5 ☐ Other (Specify)	emoval from State	Ka1baugl	n Cemetery			Elk Garde	
alti	permit. Departn Imports any inju		21. Signature of Funeral Service License	00	22	Name and Address of	of Facility	Funeral	Home, P.A er, MD 21	
m	88 = 8		Katherine	Sweitzer		710 Church	i St., K	itzmill	er, MD 21	538
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not ent	er the mode of dying, s	such as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	inabilta	y to 50	rallow				/WBECK
4	/Medical		resulting in death)	Due to (or as a do	onsequence of):	1 -				1. coks
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	end Fran	Examin	that initiated events resulting in death) Last	Due to (or as a co	no Vag Cu	nar or	19 ROYSE	<u> </u>		9FOTO
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387	icate phys s the	dical		•						
9 x	death certifica ettending ph d for use es t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Date of de	elivery
Вох	thet the death cer ed by the ettendir detached for use	ciar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim]Ectopic pregnancy] Other (specify)			Month	Day Year
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	ires thet signed b d be deta	by PI	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause given i	in Part I.	23e. Did to	bacco use contribute	
rds	w requires been sign should be	D D						1 □ Y	es 2□No 3□F	Probably 4 @Unknown
Records,	s been s shoul	Completed						24a. Was a		autopsy findings available ocompletion of cause of
æ	The law sete has page 2:	E						perfor	med? death?	'
ital		0	25. Was case referred to medical			2	6. Place of Death	(Check only o	ne)	10
\geq	g. ∠	To B	examiner? 1 Tes 2 No	ospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Hon	ne 5□Resid	ence 6 □Other (Sp	ecify)
0	ding Ph J. After th funerai	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	f 28c. Injury at Work?	t 2	28d. Describe h	ow injury occurred	
<u>Ö</u>	Attending ir death. ector: After by the fune	atic	2 Accident investigation			M 1 TYes	s 2 🗆 No			
Division of Vital	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	 At home, farm, str Specify) 	reet, factory, office	2	28f. Location (S City or Tow	itreet and Number or I m, State)	Rural Houte Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examin	sician: To the best of mer: On the basis of ex	amination and/or in	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	and due to the o	ause(s) and manner a date and place, and di	ue to the cause(s)
	the the	Med	one) 29b. Signature and title of certifier	and manner stated	ı	29c. License n	number		29d. Date signed (Moi	nth, Day, Year)
	5 <u>¥ ₹</u> 8		10. 16 /A	7	mo	nnn	11411	1	4/231	9
			30. Name and address of person who co	umpleted source of doct	h (Item 23a) /Tura	Print)	000	1		
		1	30. Name and address of person who co	Sull B	OAK	land 1	MA	21	550	
rk.	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	910				
vic.	Regist		APR 2 4 200	19 /	. A. A.	arke				

Division of Vital Records, P.O. Box 68760,

			ype or Prin									
		For State	State of Ma	ryland /	-			/lental Hy	giene	2009	14282	
		Registrar			Cert	tificate of	Death	2. Date of De	Reg. No.		3. Time of Death	
Physicia	an	Decedent's Name (First, Middle, Last)	C1 1					Month	Day 22			
/Medic		Betty Blanche 4a. Facility Name (If not institution, give st	Shank			4h City Town o	r Location of Death	April		County of Death		
Examin	er	1104 Pittsburgh A					ake Park					
Funeral		5. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birth	place (State or Foreign	
Director		376 - 46 - 1362 ^{1□}	^{M 2} ∑F 91		Yrs.	Months Days	Hours Min.	Dec. 8	, 19			
pur 🗎 🚾		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits	
Aaryla I sho	٥					ce Park					1 ☐Yes 2 ☐ No	
r 28a-f show	Director	10e. Street and Number			. Lar	10f. Zip Code			10g. Citi	zen of What Cou	untry?	
23a or	Ē	609 Dave Turney St	treet			21550			Uni	ted Sta	tes	
death	Funerai		2. Was Decedent E Armed Forces?	ver in U.S.	13. W		dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	0-			
or Ite	y Fu	1 Never Married 2 Married	d 2 ☐ Marnied 1 ☐ Yes 2 🛣 No If Yes, Give			1 ☐ Yes 2 ☐ KNo Specify:				Specify:		
72 hours "natural", adical Exe	d by	3X Widowed 4 □ Divorced	**					1.405		WI		
n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)		6a. Decede Give k! lite. D	ent's Usual Occup rind of work done O NOT use retired	during most of world)	king	160. KI	nd of Business/i	naustry	
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uld be Menta irked ific ev	0 B	James Peter Jacobs	sen				Florenc	e Sophi	la Pe	9. Birthplace (State or Foreign Country) Michigan 10d. Inside City Limits 1		
2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	e, Print)	1	9b. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State, Z	ip Code)	
and 2: eaith ai m 27 is		Terry Garlitz, Care	etaker	OCL DI	1104	4 Pittsb						
Pages 1 nent of H int: If ite		20a. Method of Disposition	moval from State	ceme	etery, crem	ition (Name of atory or other plac	ce) 4/27	7/2009	20c. Lo	cation - City or	Iown, State	
그 든 원 글		4 Donation 5 Other (Specify)		Garı			Gardens					
permi Depe Impo any ir		21. Signature of Funeral Service License			22.	David A	· Burdock	Funera	1 Ho	me, P.A	÷o.	
		23a. Part1. Enter the disease, or complic	ations that caused	the death. D	Do not ente		econd St.			MD 215.	Approximate	
Dhysisian		shock, or heart failure. List only one Immediate Cause (Final	e cause on Fach lin	e.	1 -	10	1					
Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequen	ce of):	remer	TIA				Syears	
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ficate phys s the	ope	d.										
n certi	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of								23d. Date of deli	very	
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Physician: The la this certificate has ral director, page 2								1 ☐ Yes	órmed? 2 No			
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nding ith. :: Afte	atior	1 Natural 5 ☐ Pending ✓ Accident investigation	(Month, Day	Year)	Injury	Wor	rk?]Yes 2 □No					
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification:		Dunung, atc	. (Openy)				<i>Ony</i> 0, 70	, Glate	·/		
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the hin 2, the f	Med	one)	and manner stal	ted.		29c. Licens				te signed (Monti		
Wit To O		29b. Signatury and title of certifier	Luis		9	250. Licens				-		
	#	30. Name and add as of person who cor	T filled	ath (Item 22	a) Tuna	Print)	0000	-	7.	-66.0		
	1	888 MANA COL	DR.	Ou bon	MA .	Mh 215	30 /	large a 1	A	KAISE	2009 R,M)	
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1			June		, , , , , ,		
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of	Marylar	•	rtment of H tificate of L		-	giene Reg. No. 🤈 🎧	na	14283	
Physician	1. Decedent's Name (First, Mide	dle, Last) Shirley	Rae St	roheker			2. Date of De Month April	ath Day	Year 2009	3. Time of Death	
/Medical Examiner	4a. Facility Name (If not instituti			Tonexer	4b. City, Town, or	Location of Death	-	4c. County			
Lxammer	Washington Adv	-			Та	koma Park			Montgor	nerv	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		ace (State or Foreign	
Director	577-48-5892	1 □ M 2 🕱 F	76	Yrs.	Months Days	Hours Min.				ct of Columbi	
	Usual Residence of Decedent										
- at	10a. State 10b. Count	У	10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits	
tiffied cto	Maryland Princ	ce George's			Si1	ver Spring				1 ☐ Yes 2 🛣 No	
or 28a-f st be notified Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?	
incomming to those area occurs with the may have they then "natural", or items 23a or 28a-f show ent, the Mexical Examiner must be notified at a Completed by Funeral Director	8213 Tahor	na Drive			20903			U.S.A	١		
r items 23s iner must Funeral	11. Marital Status	12. Was Dece		.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Ra	ce - Americ		
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narke narke	William O.						Thelma H		01-1- 70-	0-4-1	
h and	19a. Informant's Name/Relation	iship (<i>Type. Print)</i>		19b. Mailin	g Address (Street a	ana Number or Hu	rai Houte Numb	er, City or Town	, State, Zip	Code)	
healt ther	Jacob Wendell Str	roheker - Husi			Tahona Dri sition (Name of	ve, Silver	Spring,	Maryland 20c. Location		wn State	
or of	20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 ☐ Removal from S		cemetery, cren	natory or other plac	e)	Date	Zoc. Location	- Only of To	WII, State	
tmer tant: jury	4 □ Donation 5 □ Other		Pa		emorial Par		2/2009	Rockvi1	le, Mai	ryland	
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Musical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service	e Licensee		22	Name and Address Hines-Rin 11800 Nove	ss of Facility aldi Funer Hampshire	al Home,	Inc. Silver Sn	ring N	MD 20904	
hysician /Medical xaminer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart file is only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. Due to (or as a consequence of):										
physician and s the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cue to (cr as a consequence of): Cue to (or as a consequence of): Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown							23d. Date of delivery Month Day Year			
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sertifi ector.	25. Was case referred to medic examiner?		···		10	26. Place of Dea	th (Check only o	one)			
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ath. r: After re funera e funera	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	ing 28a. Date of (Monti	of Injury h, <i>Day, Year)</i>	28b. Time of Injury	Work	yat {? Yes 2 ∐No	28d. Describe	how injury occu	rred		
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within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:		ring Physician: To the al Examiner: On the ba and mann	asis of examina								
With To t	29b. Signature and title of certif	ier /9			29c. Licens			29d. Date sign			
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	30. Name and address of perso	Matthew 50		m 23a) (Type,	7600 C	067249 arrdl Av	enue, Ta	koma far	K, ML	20912	
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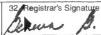
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, 2009 Year April **Physician** 1053 M Frances Savage Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery
9. Birthplace (State or Foreign
Country) Suburban Hospital Bethesda 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Days 220-56-4124 Director 85 1/07/1924 Ireland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director MD Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 5119 Brentford Drive 20852 USA items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify Specify White þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F marked William Woodford Mary Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 5119 Brentford Dr. Rockville, Md. 20852 William G.Savage/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of I Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4/17/2009 Silver Spring, Md 4 Donation 5 DOther (Specify) 21. Signature & Funeral Service L PHILIP^{Addess} RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia 3wks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ventilator dependence 3wks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last omt Due to (or as a consequency of attending physician and for use as the burial-transit 3wks Exami Polytrauma Due to (or as a consequence of 68760, Physician/Medical 0 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) I∐Yes 2⊠No P.0. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Fractured C2, Multiple facial fractures, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumothorax, Humerus fracture, autopsy performed 1 ☐Yes 2 🛛 No 1 ☐ Yes 2 ☐ No of Vital Blood loss anemia Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2 No 1☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural Fell down stairs 1415 3/19/2009 1 ☐ Yes 2 XNo death. I or Attend after death. Director: / 2 K Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5119 Brentford Dr.Rockville, Md. 20852 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide home 24 hours a Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year) 20

James Robey



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Md

2009

8600 Old Georgetown Rd. Bethesda, Md

MD

4/14/2009

D50113

April 15,2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 9:00P M April 2009 Edward Franklin Staubs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 236-42-0594 July 8, 1920 West Virginia Director 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be routhed at 10a. State 1 ☐ Yes 2 X No Director Washington Sharpsburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2224 Dargan Road 21782 Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 XIYes 2 No 1942-If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Maring once. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Government Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Pauline McAtee Charles Edward Staubs ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cathryn M. Staubs - Wife Sharpsburg, MD 21782 2224 Dargan Rd. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Samples Manor Cemetery 04-25-09 Sharpsburg, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Applice 22. Name and Address of Facility Osborne Funeral Home, P.A. Williamsport, MD 21795 425 S.Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DIZA disease or condition resulting in death) /Medical Due to (or as a co on equence of) Examiner neumonia Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner insequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 0 Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Lung Cancer 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No hx Division of Vital 25. Was case for rred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Appatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title person who completed cause of death (Item 23a) (Type, Print) Northern Ave Hagerstown MD21742 2H. 5TI MD hmood 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 23 Registrar

Please Type or Print in Black Indeligie ink./ Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:10 A M April 15 2009 Harry Edward Stockman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Northampton Manor Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☑ M 2 □ F Yrs. Jan. 4, 91 Maryland 214-14-6701 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprimer must be netitived at 1 ☐ Yes 2 ☑ No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10e, Street and Number 21701 United States 9204 Oak Tree Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 ☑ No Specify. White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be May Perkins Harry Isaac Stockman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda R. Sweeney / Daughter Frederick, Maryland 21701 9204 Oak Tree Circle 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20, 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Clustered Spires Cem: 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign ture of Funeral Service License 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** 3 week /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, learning to infinite nate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chie to (or as a nonsequence of) nel burial-transit Exami law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes After this certificate has been si funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2: No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43091 Tou House Ade, Frederick 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 06 - 104M Johanna Μ. Stul1 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimure auty 04 Ballimore HOSPITAL wai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 뮺 F Yrs. 218-32-3388 74 Aug 17,1934 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location the Marylan 10a. State 23a or 28a-f show 1 ☐ Yes 2 X No Walkersville Directo Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2813 Raleigh Road 21793 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 √2 No Specify: White ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, Ins. Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Tressler Florence Henry Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul S. Stull/Husband 2813 Raleigh Road, Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>4/21/2009 Walkersville, MD</u> 22. Name and Address of Facility Stauffer Funeral Home, PA Signature of Funeral Service Licensee Kozulm 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final - Duarraur marker Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts. Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 M No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s performed: Ves 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA **^**__Inpatient Certification: To this 27. Many r of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

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32 Registrar's Signatur

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APR 20 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

State

31. Date filed (Month, Day, Year)

APR 2 1 2009

Security S. Signature

Dr. Nooshin Farr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1500 Forest Glen Road Silver Spring, MD 20910-1484

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 24 2009 0221 Robert Lee Smith April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 **Elkton** Union Hospital 8. Date of Birth (Month, Day, Year) May 23, 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Director 235-46-2236 76 1932 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 72 Mars Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest C. Smith Ella L. Rakes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy L. Smith/Wife P.O. Box 1481, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill April 29, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Methodist Cemetery 2009 Cherry Hill, MD 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Conjustive years /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 □Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending Injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760.

154 State

Registrar

31. Date filed (Month, Day, Year)

138

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Cathedral Elleton, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goles mo

f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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Gopez,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 24,2009 LEONOR N/M/NSALLES 6:50P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS LA PLATA CENTER LA PLATA CHARLES 8. Date of Birth (Month, Day, Year) 8-30-1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Months Days Hours 1 ☐ M 2 😾 MEXICO 86^{Yrs} 215-62-9751 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits CHARLES LA PLATA 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 1 MAGNOLIA DRIVE 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATIAS PASTOR RAOUEL COUTTOLENC 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KERMITH SALLES-SON 6009 SCHENLEY LANE TEMPLE HILLS, MD. 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date | Commetting of Disposition | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | Commetter | 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISFASE ENAL MONTHS disease or condition resulting in death) Due to (or as a consequence of): 3 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 ☐Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical Death (Check only one) examiner? Hospital 1 Yes 2 No

Physician /Medical Examiner

be executed

Box 68760,

P.O.

Division of Vital Records,

or Attending Physician;

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Medical Event the cruist be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In. Mance.

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

burial-transi physician s the burial attending p for use as t signed by t I be detach

Examiner Physician/Medical þ Completed page 2 certificate ! funeral director, Be Certification: To After this

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

				I Les	10 100 2
			26. Place of Death (C	heck only one)	
1 ☐ Inpatient	2 ER/Outpatient	3 □ DOA	Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)

28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of ceptifie

5 Pending

investigation

determined

6 Could not be

29c. License number 10006018

State

Registrar

Medical

31. Date filed (Month, Day,

30. Name and address of perso

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

			1- State of Maryland / Dep. State of Maryland / Ce	artment of Health and M rtificate of Death	lental Hygien	2003 14231	
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death	
	/Medic			odorovích	April 16,		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
_			422 Pershing Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Montgomery 9. Birthplace (State or Foreign	
н	Funeral Director		578-70-0448 1□M 2X F 59 Yrs.	Months Days Hours Min.	(Month, Day, Yea	950 Yugoslavia	
١.	ס		Usual Residence of Decedent				
	anylar show	_	10a. State 10b. County 10c. City, Town or L MD Montgomery Silver S			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	Ba-f	ecto			40-7		
	a or 2	吉	10e. Street and Number 422 Pershing Drive	10f. Zip Code 20910		Citizen of What Country?	
	ns 23	eral				14. Race - American Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Its Machinal Examination and Dece.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: Caucasian	
Q 2	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	ina 16b.	Kind of Business/Industry	
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anc	uld be filed v dental Hygie rked other t tic event, L	Be	17. Father's Name (First, Middle, Last) Slavko Todorovich	Liljana	e (First, Middle, Maid	Stajic	
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	l and 2 s Health ar m 27 is her trau		Larry Kanter / Husband 422	Pershing Drive, S:	ilver Spri		
altimore,	Pages ment of H ant: If ite ury or ot		'4 □ Donation 5 □ Other (Specify) Atlantic	matory or other place) c Crematory 04/19	9/2009 G1e	en Burnie, MD	
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee M00956	Name and Address of Facility Thibadeau Mortuary 933 Gist Avenue, 1	y Service, LL, Silver	P.A. Spring, MD 20910	
			23a. Pan . Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
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)	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c.				
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9 xo	es that the death certific igned by the attending F be detached for use as	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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Records,	law ras be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
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<u> </u>	Physician: rthis certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:		h (Check only one)		
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Division of Vital	Attending or death. ector: After by the fune	tion	1 □Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No		,	
N N	Attent dea ector	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,	
	tal or rs afte al Dir	Certification:	building, etc. (Specify)		Only of Town, Sie		
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
	To the vithin To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
7	1		30. Name and address of person who completed cause of death (Item 23a) (Type	D35996	(04/17/2009	
				ry Boulevard, #400	WHEATON.	MARYLAND 20906	
• .	Sta	ite	31 Date filed (Month Day Year) 32 Registrar's Signature		,	,	
	Registi		APR 20 2009 Letur B. for	all.			
DH	MH 17 Rev 1/2	004					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day 2009 **Physician** 18, 6:10 A Morris TEPPER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery N. Bethesda Brighton Gardens of Tuckerman Lane 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y March I, 9. Birthplace (State or Foreign 5. Social Security Number Sex 1X M 2 □ F **Funeral** Year) 916 Months Days Hours Min. Palestine 93 Director 577-48-9483 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County show ir than "natural", or items 23a or 28a-f shov the Medical Expodiment must be a ciffed at 1 ☐ Yes 2 🙀 No Director N. Bethesda Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 United States 5550 Tuckerman Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 white 1 □Yes 2 🛣 No If Yes, Give Year or Dates: WW II Specify Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) 5+ Elementary/Secondary (0-12) NASA Meteorologist traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chana Goldman Ben Tzion Tepper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Kenwood Road, Garden City, NY 11530 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau
once. Dr. Bradford M. Tepper, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/09 Adelphi, MD Mt. Lebanon Cemetery 21. Signature of Funeral Service Lib nsee Törchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Date to forms a nonsecuence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Box 68760, physician the burial certificate be Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) 2 No detached o 9 Unknown 9 Unknown signed by t be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No 1 □Yes 2 No of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 28b. Time of 28d. Describe how injury occurred Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifie 29c. License number April 20, 2009 10+1 H 45839 On Name and adoress of person who completed cause of death (Item 23a) (Type, Print)

Gary E. Raffel, D.O., 11119 Rockville Pike #316, Rockville, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2009

20

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 1025 14 09 MARTHA J TALLEY 04 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CLINTON MARYLAND
If Under 1 Year If Under 24 Hrs. 8. Dat
Months Days Hours Min. (MC PRINCE GEORGES MALCOLM GROW MEDICAL CENTER 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 M 2 F 578 22 2976 67 08/13/1941 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location rail, or items 23a or 28e-f show Examilier rount be notified at 1 ☐ Yes 2 ☐ No MD PRINCE GEORGES Director DISTRICT HEIGHTS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6103 CABOT STREET 20747 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or item eny injury or other traumatic event, the Madical Examinary 2008. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specity: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HIGH SCHOOL College (1-4or 5+) PRIVATE FARMER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROLAND VINES OSCAR VINES ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6103 Cabot Street District Heights, Maryland Clarence E. Talley / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA * 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 4/23/2009 22. Name and Address of Facility 21. Signature of Funeral Service License 5538 MARLBORO PIKE 20747 FORESTVILLE MD POPE FUNERAL HOME 23a. Part1. Enter the disease, or or milications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Ura C and that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physicien Completed by Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably V known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has certificete 1 Yes 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 X FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28d. Describe how injury occurred 27. Manner of Wath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) ŝ 29c. License number 29b. Signature and title of certifier MD MI Andrews AFB, Maryla

Malcolm Grow Medical Center 1050 West Perimeter

32. Ref strarge 1050 Andrews AFB, Maryland 20762 ress of person who mpleted eause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 9

Certificate of Death

	Certificate of Death	Reg. No.
	1. Decedent's Name (First, Middle, Lest)	Date of Death Month Day Year 3. Time of Death Year
Physiciar	MARGARET LEE TAWES	April 18, 2009 12:30 PM
/Medica	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	
Examine		d Somerset
Funeral	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country)
Director	218-24-3811 1 97 Yrs. 1	March 8, 1912 Maryland
D	Usual Residence of Decedent	10d. Inside City Limits
ylan	10a. State 10b. County 10c. City, Town or Location	
W T	Maryland Somerset Crisfield	1 X Yes 2 □ No
vith the Ma or 28a-fs	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	220 57 14 1 61 1	TTC A
within 72 hours after deeth with the Maryland ene. than "naturel", or items 23a or 28a-f show he Medical Examinar must be notified at	330 W. Main Street 21817	USA acity Yes or No. 14. Race - American Indian,
ep	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 8	Rican, etc.) Black, White, etc.
age age in		Specify: White
ours a	3 kg/ Widowed 4 ∐ Divorced Year or Dates:	WIIIEG
led within 72 hours after deeth with the Marylan Vygiene. Ver then "nature!", or flems 23a or 28e-f show it, the Medical Examiner must be notified at	15. Decedent's Education 16a. Decedent's Usual Occupation (Cities kind of world does during most of world)	16b. Kind of Business/Industry
in 7	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	Somerset County
# 8 # 8	Music Teacher	School System
other of her	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maiden Surname)
		ri e
marked umatic	1	
and and and and and and and and and and	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	l Route Number, City or Town, State, Zip Code)
4430	John P. Tawes, III (Great-Nephew) 8 Anchor Drive - Crisfi	ield, Marvland 21817
- ¥ 2 €	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
5 = 5	1 □ Burial 2 □ Cremation 3 □ Removal from State	
Land Land		22/2009 Marion Station, Mary
permit. Per Department important: any injury once.	21. Signature of Funeral Service Livens BR/	ADSHAW & SONS FUNERAL HOME
89 2 2	306 W. Main Street -	- Crisfield, Maryland 21817
	Marat Della Desatalana Descritt	_
10.00	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on eech line.	Interval Between Onset and Death
Physician 1		
/Medical	Immediate Cause (Final disease or condition PNEUMONI A	,
Examiner	resulting in death) Due to (or as a consequence of):	
executed in and ial-transit	b	
certificate be executed vding physician and use es the burial-transit	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate	1
Se es	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):	
certificate be executed nding physician and use es the burial-transit	that initiated events Due to (or as a consequence of): resulting in death) Last	
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The law requires that the death sete has been signed by the atte page 2 should be detached for	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	23b. Did tobacco uaa contribute to the causa of deat
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v require been sig should b		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
The law requir		completion of cause of death?
has has	'	
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ysicia is certi direct	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA Ottel: 4 ☐ Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)
rthis gral o		28d. Describe how injury occurred
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or Attending efter death. Director: After I in by the fune	2 Accident Investigation 3 Suicide 6 Could not be 280 Place of Injury. At home, farm, street, factory, office	28f. Location (Street end Number or Rural Route Number,
or Att	3 ☐ Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide Suicide	City or Town, State)
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Hospital 24 hours Funeral stely filled	29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, a	and due to the cause(s) and manner as stated.
To the Hospital or within 24 hours effer To the Funeral Dire completely filled in b	(Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date and place, and due to the cause(S)
ithin mpl	29b. Signature and title of certifier / 29c. License number	29d. Date signed (Month, Day, Yeer)
5.≱₹.8 _	D 48098	04/18/2009.
	J 750 18	04/18/2001
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)	(B) (5) 3 - A
	D. VDAY KARUMBUNATHAN 201 HALLHIGHE	WAY, CRISFIELD, MD, 2181
4 1	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	
State	31. Date filed (Month, Day, Year) APR 2 1 2009 Server B. Jacks	
Registra	p. pares	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** April 18, 2009 12:35 PM Barbara Ann Grier Varady /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Union Hospital of Cecil County Elkton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2XXX Director 72 March 28, 1937Pennsylvania 213-36-9842 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, tre it salical Examinar must be notified at 1 ☐ Yes 2XXNo Directo North East Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21901 United States 2884 Turkey Point Road Funeral s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 257No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No Specify: White Completed by 3 ☐ Widowed 4 😾 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Gentry Sam Phillippe ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2884 Turkey Point Road, North East, Maryland21901 Wayne T. Grier / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 21, Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 2009 Newark, Delaware 21. Signature of June 11 Service Licens 22. Name and Address of Facility Crouch Funeral Home /alul 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of): Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit 1.CR Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 ☐No 9 Unknown is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 04-28-2009 9:30 A M Deloria Ann Whitely /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mt. Lake Park 110 A Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🗓 F 71 Yrs. 02-20-1938 Ohio Director 286-34-8341 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State "natural", or iteme 23a or 28a-f ehow 1X Yes 2 No Mt. Lake Park MD Garrett Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21550 110 A Street Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ont: If Item 27 Ie marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home 11 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pattie Smith Roy Harper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 466 Waterfall Lane, Whigham, GA Kelly Robertson, Daughter 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Buriat 2 X Cremation 3 Removal from State = 5 permit. Page Depertment of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 04-30-2009 Cumberland, MD Scarpelli Crematory 22. Name and Address of Facility Fredlock Funeral Home 21. Signature of Funeral Service Licenses 26750 31 Jones Street, Piedmont, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) 1 year Pnysician Heart failure /Medical Due to (or as a consequence of): Examiner years Chronic obstructive pulmonary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ል as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiac arrhythmia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page this certificete 1 Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 XNaturat 5 Pending 1 Yes 2 No М investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital within 24 hours a 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RO60312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date fited (Month, Day, Year)

APR 29 2009

Linda ST Stresky, MS, CRNP 32. Registrar's Signature banks

311 N Fourth Street

21550

Oakland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 3:15AM Scott 2009 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sail Sbu -vastal Hospice at the Lake COMICE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-1-196 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** 1 M 2□F Min. Hours Months Days 315-86-4085 Usual Residence of Decedent Director -1-1964 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event; it "Adden Event", in out to nother traumatic event; it "Adden Event". 1 □Yes 2 No Somerse Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21838 154 Completed by Funeral orner 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after leatth and Mental Hygiene. 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Bleck 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) andscuper 18. Mother's Name (First, Middle, Maiden Surname)
Erances V. McCready, 17. Father's Name (First, Middle, Last) Be Frances PUNCES 19a. Informant's Name/Relationship (Type. Print) (Father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranford Williams Marion Station 147 21838 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State 4-21-0 pmetery 21. Signature of Funeral Service Licensee 22. Name and Address of Harris-Nock F.S. 7.0 Bridgeville Ve 60 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20. Immediate Cause (Final **Physician** disease or condition resulting in death) small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) error.SLU.WCHD. The law requires that the death certificate be executed Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown out clerical 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1) Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 1 ☐ Yes 2 □ No 1 ☐ Yes 18, Crossed out Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) DICE 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After the Funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the funeral Director of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat of death (Item 23a) (Type, Print) a ress of person who completed cau e

State Registrar

istrar APR 20 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** James Car 200 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9325 Colonial Mill Drive Delmar Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**XX**M 2□ F Yrs. 93 Nov. 29, 1915 Director 214-10-9701 Marvland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Delmar Wicomico Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 9325 Colonial Mill Drive 21875 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ 3 Widowed 4 Divorced white WWII Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na eny injury or other treumatic event, If a Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) 10 Owner Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Carl Williams, Sr. Grace Elizabeth Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 9325 Colonial Mill Drive Delmar, MD Nora Smith Williams 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donetion 5 ☐ Other (Specify) Wicomico Memorial Park Arpil 20, 2009 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 19940 Delmar, DE Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No investigation the Director. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🔼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. 6ignature ar ed cause of death (Item 23a) 30-Name and adding 31. Date yied (Month, Day, Year) 32. Registrar's Signature State APR 20 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended item#10e, WCHD, SLU, 4. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Victor : 37 PM Wilbekin 0 4 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NICOMION 50/15641 MEDICAL TENINSULA REGIONAL If Under 1 Year | If Under 24 Mrs 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 ☑ M 2 □ F 30-1919 084-22-334 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedienl Experience must be notified at 1 Yes 2 No Director Wicomico NANTICOKE 10e. Street and Number 2633 Bank 10g. Citizen of What Country? 10f. Zip Code Bank Road Q. Box USA 21840 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1978es 2/7No
179s, Give
Year or Dates: 755-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NISTRATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ GREMIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type, Print) DON) SEREMIAN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -22-09 4 □ Donation 5 □ Other (Specify) REDGIORU 21. Signature of Funeral Service Liger 22. Name and Address of F Steward FILNERA HOME 821 23a. Part1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardinal or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherescleratio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 Z No 1 ☐Yes 2 ZNo Division of Vital Pospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident upletely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

32. Pegistrar's Signature

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Reilly

560 Riverside Dr. 8101

Salisburg

Md.

Baltimore Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			For State Registrar	i icase	State of Ma		d / Depa		Health and N	Mental Hyg		n n n	11.200
	Physicia		1. Decedent's Name							2. Date of Dea Month	th Day	Year 2009	3. Time of Death
	/Medic Examin		4a. Facility Name (li	f not institution, giv	re street and number) 7 Hospital			4b. City, Town	or Location of Death	Trijov v v	4c. Cour	ity of Dear	
ı	Funeral Director		5. Social Security No. 215–18–68	umber 6. S		e (In yrs. la 86	nst birthday) Yrs.	If Under 1 Year Months Day	r If Under 24 Hrs.	8. Date of Birth (Month, Day Feb • 12	, Year) , 1923	Co	thplace <i>(State or Foreign</i> buntry) ryland
puolino	show	'n	Usual Residence of 10a. State Maryland	10b. County	ton County		Town or Loc						10d. Inside City Limits 1 X Yes 2 □ No
M odt diw	a or 28a-f	Director	10e. Street and Nun			nag	erstov	10f. Zip Code 2174		· ·	10g. Citizen o		ountry?
d ZIZIJ-0030	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status	ed 2 Married	12. Was Decedent E Armed Forces? 1 MYes 2 1 If Yes, Give 1 Year or Dates 1	8/.3-			f Hispanic Origin? (Sp Jban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	U.S 14. R B	ace - Ame lack, White	erican Indian, e, etc.
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Maly 12 sho	th and Iv	_	19a. Informant's Na Rosalie						et and Number or Ru Lane, Hag				Zip Code)
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TIIII	rtment rtant: I		4 ☐ Donation	5 ☐Other (Specif	fy)	Smi	thsbur	g Crema	tory 4-22	2-2009	Smiths	burg,	Maryland
ם פ	Important land		21. Signature of Fu	tieral Service Licel	Haren				$^{ ext{dress of Facility}}$ $^{ ext{Dc}}$ $^{ ext{ern}}$ $^{ ext{Blvd}}$.				
	hysician /Medical xaminer		23a. Part 1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only (Final	prications that caused one cause on each lin a. A 77 Due to or as a	o Ro	n pr	er the mode of c	lying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequen						to		unge_					
the death certifical	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the total the funeral director.	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗀 Fetal	death 3	☐ Ectopic pregna ☐ Other (specify,				Date of de Month	blivery Day Year
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The law re	ate has bee	Completed								24a. Was a autop perfor 1 □Yes	sy	b. Were a prior to death?	
VILO sician:	certific rector,	Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☐		Hospital:				26. Place of Dea				
5 6	ter this neral di	n: To	27. Manner of Death	h	28a. Date of Inju (Month, Day	ry	28b. Time of Injury	IT 3 LI DOA	4 □ Nursing Hi ijury at /ork?	ome 5 ☐ Resid 28d. Describe h			ecity)
IVISIO TAffendir	tter death. irector: Af n by the fur	Certification:	2 Accident 3 Suicide 4 Homicide	5 ☐ Pending investigatio 6 ☐ Could not be determined	n Place of Inju	ury - At hor	me, farm, str	M 1	□Yes 2□No	28f. Location (S City or Tow	Street and Nu n, State)	mber or R	tural Route Number,
Hospital	24 hours a	Medical Ce	29a. Certifier (Check only one)	2☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	f examinat	ion and/or in	vestigation, in m	y opinion, death occu	rred at the time,	date and plac	ce, and du	e to the cause(s)
Tothe	within To the comple	Med	29b. Signature and	title of certifier	and manner see	itou.		29c. Lice	ense number		29d. Date sig	ned (Mon	nth, Day, Year) /2009 MO 21740
)			30. Name and addr	ess of person who	completed cause of d	eath (Item	23a) (Type,	Print)	62440		4	122	1200-1
34	9+1		31. Date filed (Mont	Tarosic th. Day Year)	W Kalke	ar's Signat	SI E	ast an	tolan S	t. Has	zersto	wn	MO 21740
	Sta	te	C., Date mod prom	APP 2 2 2	000	ga.	1 1	-11					

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Amend 29d per MD 8891 5.5. The Type State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2009 11:46 A M 4 James Michael Amos 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges 1908 Ardlyn Court Bowie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 214-60-0937 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Hours 1 X M 2 □ F Months Days 03/02/1952 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716 U.S.A. 1908 Ardlyn Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Retail Clerk</u> Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Stricklin Billy Amos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Ardlyn Court, Bowie, MD Lynn Amos/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Ardent Cremation Services | 04/29/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licknisee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any reading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dun to (or as a nonsvicumen of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 26. Place of Death (Check only) Hospital Other: 4 \(\sum \) Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

/Medical **Examiner** Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a d be detached f this certificate has been sial director, page 2 should After 1 Hospital or Attending 24 hours after death, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital within 24 hours a To the Funeral D

Physician

/Medical

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Examiner

Funeral

Director

28a-f show

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.

wirt. If item 27 is marked other than "ratural", or items 23a or 28a-f show and it is not other traumatic event, its Modest Exercise. That he notified any or other traumatic event, its Modest Exercise.

permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once.

Physician

Baltimore, Maryland 21215-0036

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed funeral director, 25. Was case referred to medical examiner? Be 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

900 Be strate

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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State

Curtes

31. Date filed (Month,

4/27/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 200 3,400m Joseph Ronald Atkinson Sr. tori /Medical Facility Name (If not institution, give si or Location of Death County of Death 4b. City. Town 4c Examiner 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Min 214-34-3669 13, Director Maryland Dec. 1937 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other tranual or or the tranual or or other tranual or or other tranual or or other tranual or or other tranual or or other tranual or or other tranual or or other tranual or or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tranual or other tran 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Pepperwood Springs Way 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Quality Assurance Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Atkinson ည Helen Virginia Krogman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff L. Atkinson / Son 1209 Pepperwood Springs Way, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Zion U.M.C. Cem. 5-2-09 Bel Air, Maryland of Fund al Service Lic 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ____ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-tran Due to (or as a consequence of): the attending physician hed for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □No o. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Vital 2 1No 1∏Ýes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital: Other 1 Yes 2. No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Mapper of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title_of certifier

3x1

State Registrar 30. Name and address of person w

31. Date filed

o completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav 6:24 A M **Physician** April 29, 2009 Margaret G. Alger /Medical 4a. Facility Name (If not institution, give street and number)

1436 Morling Avenue 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M **20X**F 219-20-9711 Aug. 25, 1923 Maryland 85 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at XXYes 2□No Maryland N/A Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 1436 Morling Avenue 21211 USA ms 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or items, the Medical Examiner me 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify **≥** 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Executive Assis. Hedwin Plastic College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ury or other traumatic event, the M unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Blaine Hubbs Be Effie Jane Painter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanette Tsamouras (Granddaughter) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 2411 Haddon Hurst Ct. Fallston, MD 21047 **Baltimore**, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Abrahams Cem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 □ Cremation 3 □ Removal from State 5/2/9 Beckleysville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility, Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 21. Signature of Funeral Service Approximate Interval Between 9nset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each library arrest. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 4☐Pregnant at time of death P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No has certificate I Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 【Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No ٩ this 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident vithin 24 hours are control to the Funeral Director 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b Signature and title of corlifie 2 Allending MD 17118

State Registrar 31. Date filed (Month, Day, Year)

30. Name and ad

32. Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

M.D.

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		1-	For State Registrar	State of Mary		artment of Hertificate of E	Death	Reg	g. No.	14304
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	miner	4a	. Facility Name (If not institution, give Future Care Charl			4b. City, Town, or Baltim		/	4c. County of Death	
Funei Direct	_		Social Security Number 6. Security Number 1	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 June 4, 1	9. Birthpl Count Mary	ace (State or Foreign ny) and
yland		_	oa. State 10b. County	10	c. City, Town or La	ocation			10	d. Inside City Limits
e Mar Ba-f et	Director		MD n/a		Baltin	NE E				Yes 2 No
h with th	Dir	10	ne. Street and Number 1421 N. Central	Avenue		10f. Zip Code 21202		10	g. Citizen of What Count USA	ry ?
72 hours after death with the Maryland relatural; or Iteme 23e or 28e-f ehow dical Exeminar must be notified at	by Filmeraí		. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No I If Yes, Give Year or Dates:	Armv	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2🛣 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	rify Yes or No- lican, etc.)	14. Race - America Black, White, e Specify:Black	tc.
2 2 3	Completed		15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done d	tion uring most of workin	g 1	6b. Kind of Business/Ind	ustry
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Id be filed Aental Hygi riked other	9	17	7. Father's Name (First, Middle, Last) Edward Allen				18. Mother's Name		laiden Sumame)	
re, wat yia s 1 and 2 should t Health and Men ttem 27 is marke other traumatic			9a. Informant's Name/Relationship (7 Bertha Mae Allen				nd Number or Rural 1 Ave. Ba		City or Town, State, Zip 21202	Code)
Dallillore, permit. Pages 1 a Department of Her important: if item			Da. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Dother (Specify	Removal from State) Mausoloum	King M	matory or other place lemorial P	k. May 7	, 2009	Baltimore,	
Dermit. Depart Import	Suc	2	1. Signature of Funeral Service Licen	The luce	/ 8	Name and Addres alvin B. 1412 F. P.	Scruggs F	uneral H	Home ,Md. 21213	
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VITAL IN sician: The certificete h	a	2:	5. Was case referred to medical examiner?	Hospital:		1.0%	26. Place of Death	• • • • • • • • • • • • • • • • • • • •		
Physic r this c	F		1 ☐ Yes 2 ☑ No 7. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 Nursing non		nce 6 Other (Specify	1)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** one /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death nty of Deat Examiner Atans ville more Ursing a Age (In If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, yrs. last birthday) 9. Birthplace (State or Fpreign **Funeral** Min. MANCH 8 1 MM 2□ F Months Days Hours **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits or other traumatic event, the Modical Examiner must be notified at Yes 2 □ No **Funeral Director** imore 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White Etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) most of working and Elementary/Secondary (0-12) College (1-4or 5+) porrectiona (First, Middle, Maiden Surname Be 8,0 ဂ 150 mant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number of 19a. lg Plural Route Number, City or Town, State, Zip Code, O CON 20a. Method of Disposition City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State nu tus 4 Donation 5 ☐ Other (Specify) 22. Name and Address of F 21. Signature of Funeral Service Cicensee the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death art Enter shr ck, or he Lum diate Cau e (Final lease or condition resulting in death) Physician [,] /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and of in by the funeral director, page 2 should be detached for use as the burial-transit din by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 210 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□ Yes 2⊅1€ Other: 4 Sursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Moun

Spris

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician **Anna Brandford** May 2, 2009 0011 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Harbor Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 □ F Months Director Maryland Jul 12, 1936 <u> 213-36-3546</u> Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any highry or other traumatic event, the Modical Examiner must be notified an once. 1 X Yes 2 □ No Director **Baltimore** N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 1106 Sterrett Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Specify: ş Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertie Brandford Joseph Brandford ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 237 North Gilmor Street Baltimore, Maryland 21223 Sean Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Md. 05/08/09 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mausoleum 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 155eminate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Winary Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 MER/Outpatient 3 □ DOA ٩ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifie 29d. Date signed (Month, Day, Year) mergency hysician epax Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:35a Apr 18, 2009 Rickey Brandford /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner N/A Baltimore University Maryland Medical System If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 M 2 □ F Maryland Jan 22, 1954 Director 212-60-6485 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at ¥TYes 2 □ No r 28a-f sh notified Baltimore Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r U.S.A. 21230 1106 Sterrett Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 72 hours after 1 ∏ Yes 2 ∏ No If Yes, Give Year or Dates: 1976 1 ☐ Yes 2 No Specify: Specify: 3altimore, Maryland 21215-0036 Black <u>۾</u> 3 Widowed 4 Divorced 1978 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Federal Government College (1-4or 5+) Elementary/Secondary (0-12) Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Brandford Isaiah Rouzer ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1255 Carroll Street Baltimore, Maryland 21230 of Health Shawntale Brandford Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Owings Mills, Md. 04/28/09 4 Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Lica see 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final week Physician Sepsis-Gram Negative Bacteremia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ó 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ Severe Peripheral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Hepatitis A, Hepatitis B, Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an Vascular Disease with gangrene, Acute Renal page 2 autopsy performed? res 2X No Insufficiency 1□ Yes certificate or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ XIo 1 🔣 inpatient 2 ER/Outpatient 3□ DOA ဥ this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu death. 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 MID 18179 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith, 22 Street, Baltimore, Md. <u>Catherine</u> South Green

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03575 2009 14308 State of Maryland / Department of Health and Mental Hygiene Robert Bucher, Jr 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 3, 2009 2010 hrs Robert Michael Bucher, Jr. Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford 202 White Oak Court Apt. A Abingdon If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Country Towson, Maryland Hours Months 11/20/1987 214-25-6887 Director 21 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No MD Baldwin Harford tem 27 is marked other than "natural", or items 23a or 28a-f slov traumatic event, the Medical Examin<u>er must be notified at once.</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2713 Pemberton Ridge 21013 U.S.A. 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes Specify: White f Yes. Give Yeer Yes 2 X No specify: Widowed Divorced 5 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Walmart Stock MD 21215-0036 Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cheryl A. Fundak Robert M. Bucher, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Father 2713 Pemberton Ridge, Baldwin, MD 21013 Robert M. Bucher, Sr. item 27 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Evansy of theral Chapel- Bel Air Burial 2 X Cremation 3 05/05/09 Removal from State Forest Hill, MD Chapel-Other Specify: Donation 5 Evans of Funeral Chapel & Cremation 3 Newport Drive, Forest Hill, MD 21. Signature of Funeral Service Licenses er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Intraoral Gunshot Wound mmediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an autopsy has performed death? Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot self FOUND: Division Natural Yes 2 V No Pending death. the May 3, 2009 2010 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be

Death Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Residence 6 Other: Scene 28f. Location (Street and Number or Rural Route Number, City within 24 hours after d To the Funeral Direct completely filled in by or Town, State) 202 White Oak Court Apt. A, Abingdon, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 4, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL**

Service 21050

Cedric DOENTE Banks 09-03477 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 30, 2009 1135 hrs Medical Examiner Cedric Doente Banks 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cecil 31 River Road Perryville If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Director 159-58-0281 32 1**X** M 2 July 14,1976 Pennsylvania Yrs Usual Residence of Decedent 10d. Inside City Limits any 10a. State Ob. County 10c. City, Town or Location 1 Yes 2 X No Delaware New Castle Bear Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 23a or 28a-notified at 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1125 Woodchuck Place 19701 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 **X** No Yes Yes 2 No specify: Specify: Black Widowed Divorced Yes, Give Year Ď 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) narked other than ' MD 21215-0036 2 Customer Service Sales 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) narked Be Harry Washington Sheila Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is n r traumatic Sheniece K. Banks/Wife 1125 Woodchuck Place Bear, DE 19701 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, portant: If it ury or other t crematory or other place) Burial 2 X Cremation 3 Metro Crematory, Inc. 5/4/09 Baltimore, MD Donation 5 Other Specify permit. Cremation Society of Maryland, 21. Signature of Funeral Service Licensee C. Todd Dring <u> 299 Frederick Rd Baltimore, MD</u> 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Drowning Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Yes 2 V No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has h performed? death? 1 Yes ✓ Yes 2 No. 2 No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury Certification: Subject jumped into river FOUND: 1 Natural Yes 2 ✔ No Pending hours after death Apr 30, 2009 1000 hrs 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) Thomas J. Hatem Memorial Bridge, Perryville, MD determined (Specify) River 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29h 5 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 1, 2009

111 Penn Street, Baltimpre, MD 21201

Registrar

OCME 2006

State

Laron Locke MD. A
31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MARY L. BENNER 905 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/24/1924 9. Birthplace (State or Foreign **Funeral** Hours Days Min. 218 22 9140 1 □ M 2 🗶 F MARYLAND 84 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expriner must be notified at MD BALTIMORE ROSEDALE Director 1 □ Yes X□ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 957 ROSEDALE AVE 21237 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: WHITE 3 Widowed 4 Divorced filed within 72 hours Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EMORY** SAPP STELLA HUGHES မ permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILLARD BENNER/SON 2140 REDTHORN ROAD MIDDLE RIVER, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 5/4/09 METRO CREMATORY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (\$pecify) 21. Signature - Formatti Survice Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Effu Siun Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hem othorax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Poeum Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi neumonia Due to (or as a consequence of): P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No hours after deatl uneral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 061907 5-01-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRanklin Square DR Balto Md Z1237 EBO

State Registrar

DHMH 17 Rev 1/2001

Chukwuma 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

			Please	Type or Print in Blac AMEND TTEM#1 per State of Maryland /	k Indelible Ink PHYS G891 5 Department of	712/09, WS Health and M	Copies Are	Legible. e	
			1 - For State Registrar		Certificate of		Reg. N	2000	1431
	Physic /Medi		1. Decedent's Name (First, Middle, Las	Mildred	Ellen Boon	е	2. Date of Death	0 2009	3. Time of Death
and the second	Examir Funeral Director	ner	4a. Facility Name (If not institution, give	ounty Gener	al Coli		8. Date of Birth (Month, Day, Year	9. Birthp	place (State or Foreign PA
	w		Usual Residence of Decedent 10a. State 10b. County	10c. City. Toy	vn or Location		PLAT		0d. Inside City Limits
	h the Maryli or 28a-f sho	Director	MD Houx 10e. Street and Number	ard F	10f. Zip Code	7	10g. C	Citizen of What Coun	1 ☑ Yes 2 ☐ No
	ath wit	ral	4641 S. Lei	sure Court		541C		AZU	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational be indiffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Worced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 To If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spe pan, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
15-0	"natur	leted	15. Decedent's Ed (Specify only highest grad		a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	16b.	Kind of Business/Inc	dustry
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homer			Domes	tic
	be filed tal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)	8		18. Mother's Name	(First, Middle, Maide	n Surname)	
Maryland	should be and Mental Is marked o	은	19a. Informant's Name/Relationship (7	ype. Print) 19	b. Mailing Address (Street	t and Number or Rura	I Route Number, City	or Town, State, Zip	Code)
	1 and 2 Health a em 27 Is ther tra		Carol Egar	1 / daugnter 5		ots Oak	< Rd Co	lumbia,	MDZIOHY
nore	Pages 1 nent of H int: If itel iry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐	Removal from State	of Disposition (Name of ery, crematory or other pla	nce)	ate 20c.	Location - City or To	wn, State
Baltimore,	permit, Pages 1 al Department of Hee Important: If item any Injury or othe once.		4 Donation 5 Other (Specify 21. Signal of Filmeral Service Lies		22. Name and Addre	ess of F cility	1:01 13	1/1/10/10/20 J	18434 DEC PA
1	Physician /Medical Examiner	ner	23a. Part 1 Enter the disease, or compshops, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	lications that caused the death. Do ne cause on each line. a. Due to (or as a consequence) Due to (or as a consequence)	in hear	ing, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	of):				
.O. Box 68	or Attending Physician: The law requires that the death certificate be executed after death. Interdor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed I should be deti	è	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause gi	ven in Part I.		ouse contribute to th 2 □ No 3 □ Prob	ne cause of death?
Vital Records,	: The law re cate has bee page 2 sho	Completed					24a. Was an autopsy performed?	prior to cor death?	psy findings available mpletion of cause of 2 No
Vita	siclan; The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Oti	26. Place of Death			
n of	iding Physiclan; th. After this certifica funeral director, p	on: To	27. Manner of Death		Time of 28c. Injury Wor	4 LI Nursing Hon	ne 5 Residence 8d. Describe how inju	. , ,	<u>v)</u>
Division	I or Attendir after death. I Director: A' d in by the fu	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	M 1 🗆]Yes 2□No	8f. Location (Street a City or Town, Sta	and Number or Rura te)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowledginer: On the basis of examination a	je, death occurred at the t nd/or investigation, in my	ime, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as s	stated. the cause(s)
	To the within To the comple	Med	29b. Signature and fittle of certifier	and manner stated.	29c. Licens	se number	29d. D	Pate signed (Month,	Day, Year)
	3		30. Name and address of person who d	ompleted cause of death (Item 23a)	(Type, Print)	Codar L	one Ci	abic MT	2 31000
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2009	32 Registrar's Signature		Court Las	MIN, COUNT	TOKALITE	2 41017

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** BRYANT 228 1CHARD 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. Yrs Director 220-24-9253 79 May 31, 1929 Baltimore, MD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene.

n 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Properties it if item 21s a marked other than "natural", or items 23a or 28s-f show Important; if item 27 is marked other than "natural", or items 23a or 28s-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1115 Oakview Drive USA Funeral 21032 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer 6 Food Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert Skillman Bryant Emma Roberta Piquett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Mrs. LuAnn Davis / Daughter 1115 Oakview Drive Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 8, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Mem Park 22. Name and Address of Facility Singleton Funeral and Cremation 21. Signature Euneral S ce Licensee Services, 1 2nd Ave SW 161220 Glen Burnie, MD 21061 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shrick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RICINSON Physician lan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Nother (Specify) HOSPICE Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? HUXISE 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier

Division of Vital Records,

State Registrar

31. Date filed (Month, Day,

Name and address of a

m NI 32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print).

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Juanita Bradshau May 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HOSPITAI Harre de Memorial Grace Hartord Har ford Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🗗 F Director 219-32-5670 Usual Residence of Decedent Apr. 11, 1936 Maryland 10a. State 10b. County 10c. City, Town or Location fshow 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland | Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1816 Steven Drive 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify ģ Specify Baltimore, Maryland 21215-003 3 □ Vidowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 School Secretary Private Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ernest Eugene Ecker Catherine Wilhelmina Whitesell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Polly Shunk / Exec./Friend 2609 Philadelphia Rd., Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 5-8-09 Parkwood Cemetery Baltimore, Maryland 21. Signatur uneral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Lancer unknown nding physician and use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atten for us 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? dementia 1 ☐Yes 2**%**No Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ∐Yes 2√Q No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMPSON

5

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 8:28 P M MAY 3, 2009 EVELYN CAROLYN BENSER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 525 Eckhart Drive Joppatowne If Under 14 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 ☐XF 19, 1943 Maryland Director 217-40-4684 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10h County ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 USA 525 Eckhart Drive Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 College (1-4or 5+) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) Retail Sales 5+ Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Anthony (unk) Pishalski <u> Maude (unk) Robinson</u> မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau 525 Eckhart Drive, Joppa, Maryland, 21085 Raymond Benser / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Dentation 5 ☐ Pother (Specify 3 🗆 R Bel Air, Maryland Bel Air Memorial Gdn. 5/7/2009 21. Sign ture of Funda Service 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast CANCER 15 Years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of): Box 68760, signed by the attending physician a be detached for use as the burial-The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 No After this certificate funeral director, page 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

31. Date filed (Month, Day, Year) MAY 0 5 2009

29b. Signature and title of certifier

M. Alabrash, MD 5430 Campbell

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Bivd # 213

D37612

29d. Date signed (Month, Day, Year)

white Marsh MD 21162

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** 5:00A 28, 2005 4c. County of Death Emory Lee Breeding April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4722 Ruby Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ₹M 2 □ F 85 226-22-8272 1923 Aug. Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ir o l'odical Examination usat ou notified a once. 1 □Yes 🎾 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4722 Ruby Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White <u>6</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic Sheet Metal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elbert Breeding Ettle Dotson ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Breeding - Daughter 4722 Ruby Avenue, Baltimore, 20a. Method of Disposition

13 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Meadowridge Memorial 5-1-2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park
2. Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Service Lite 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con quer Examiner Sequentially list conditions, if any, loading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Yes After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed yes 2 2 No 1 ☐ Yes 26. Place of Death (Check only on-25. Was case referred to medical examiner? Be 2 No Other: 4 \sum Nursing Home Hospital: Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural ∠ □ Accident 5 ☐ Pending investigation n 24 hours after death.
he Funeral Director: Aff
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor **To the Fune** completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person

32. Registrar's Signature

1. barket

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Month WASYL BOHDAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 8. Date of Birth (Month, Day, Year)
AUG. 10,1920 UKRAINE 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 212-32-9667 1 XM 2 ☐ F 88 Director Usual Residence of Decedent Show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examinar must be notified at Director 1X Yes 2 ☐ No MD WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 18209 SUMMERLIN DRIVE 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUGAR BOILER DOMINO SUGAR CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be N/A BOHDAN ပ္ SOPHIA N/A19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA SCHWARTZ/DAUGHTER 18209 SUMMERLIN DRIVE, HAGERSTOWN, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAELS UKRAINIAN 5/4/09 BALTIMORE, MD. 21. Signature of Fu LTLLY & ZEILER INC.FUNERAL FOME 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** enphone disease or condition resulting in death) month /Medical Due to (or as consequence of): Examiner spiration wak Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed Rinal 1 week attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year signed by the a 5 ☐ Other (specify) P.O. 1 TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy Physician: The perform 2 2 40 1 □ Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 124 hours after death.

Le Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 28365

Registrar
DHMH 17 Rev 1/2001

State

368 mill

Herestaum

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

SHAM

32. Registrar's Signature

19 ANZ

31. Date filed (Month, Day, Year)

AR

5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland, Department of Health and Mental Hygiene rar Certificate of Death Reg. No. Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SUN APRIL 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES AREY BROOK OXON 14126 8. Date of Birth (Month Day, 9. Birthplace (State or Foreign Country)
South Korek If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F SZ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at OXON HILL 1 XYes 2 ☐ No PRINCE GEORGRS Director MD 10g. Citizen of What Country? 201145 U51 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: ASIAN If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Completed by 3 ₩idowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WIFE 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 50N ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CRIMINATURY APRIL 29-09 20c. Location - City or Town, State 20a. Method of Disposition BALTIMORE, MV 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility to wold Fune Rul Bomt 21. Signature of Funeral Service Licenses Rd 12550 10220 GULFORd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or es a consequence of): Intaction disease or condition /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) med by the a detached for 1 ☐Yes 2 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 No of Vital 24 hours after death.

Funeral Director: After this cer fice letely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Horsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 17 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner as stated. 29a, Certifier within 24 hour To the Funer completely fill and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) When Roh. m.D. 018092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) **MAY 0 5 2009**

32. Registrar's Signature

5/07 Silva Hill Rd Switlend

20746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decoden's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:25AM 1101 200 Cia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4 aines MOYE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 7. Age (In 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 1 F and Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the finding Evan instrument by multiple of 1. Yes 2 □ No Funeral Director 10 more 10g. Citizen of What Country? 10f. Zip Code Street and Number 12. Was Decedent Ever in U.S. Armed Forces?, 1 | Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 □Yes 2 No Specify Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Mother's Name (First, Middle, Maiden Surname) er's Name (First, Middle, Last) 18. 10mac မှ (19b. Majling Address, (Syeet and Number or Rural Boute Number, City or Town, State, Zip Code) daughte of Health a Important: If item 2 any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Denation 5 Other (Specify) Signature of Funeral Service Licenses rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final disease or condition resulting in death) Onset and Death chydration **Physician** ay /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events and the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the Examiner Due to (as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1□Yes 2□No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ≥ ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man - of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

law requires that the death certificate be executed and attending physician for use as the buria P.O. the cate has been signed page 2 should be det Records, certificate has Physician: The of Vital this After t Hospital or Attending Division within 24 hours after death.

To the Funeral Director: / filled in by the

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene.

4 🔲 Homicide

29a. Certifier

(Check only one)

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the liftle, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Raltimore

29d. Date signed (Month, Day, Year) 2009

Mason Tonya 31. Date filed (Month, Day, Year)

9005 Cation

32. Registrar's Signature

State Registrar

completely

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give Examiner oge (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Yrs. orgia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Worlda Evand and other traumatic event, the Worlda Evand and other traumatic event, the Worlda Evand and other traumatic event. 10b. County 1 Xyes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces? 1 No 1 Yes 2 No 1 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>6</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 1 and 2 should be Health and Mental mae ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau Augusta st - WIFE UNK. Date 20b. Place of Disposition (Name of cemetery, crematory or other place), 20c. Location - City or Town 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthailure. List only one cause on each line.

Immediate Cause I Final disease or condition resulting in death)

a. VN(_ C A ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... ~ ... 21 Sign sure of Funeral Service Lio nsee 22. Name and Address of Facility 340.5 Approximate Interval Between Onset and Death **Physician** MONTH /Medical Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 1 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> pe 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 NO 1 ☐ Yes 2 🗆 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 100 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours a To the Funeral C vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05-05-2009 30. Name and address of person who completed cause of death (Item 2 a Type, Print) ANANDA 821

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MEE KINS 1:07 AM GLORIA CLEMENTS 2009 APRIL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min 1 M M DF Maryland Oct 3, 1929 213-26-9496 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 Yes 2 No Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21061 103 Warfield Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security Administration Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Meekins William Meekins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Charleswood Court Baltimore, Maryland 21207 Kimberly Dandridge 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 05/04/09 Windsor Mill, Md. King Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY ANOXIC 2 days Due to (or as a consequence of): 2 days HYPERTENSION EMERGENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

this Aftar

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, signed by the a vis certificate has been s director, paga 2 should after death.

I Director: Aid in by the fu

within 24 hours aft

To the Funeral Di

completely fillad in

the

State Registrar

Physician/Medical <u>۾</u> Completed Be Certification: To

Medical

29a. Certifier (Check only one)

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar most be notified at

permit. Pages 1 and Bepartment of Health Important: If Item 27 any Injury or other troone.

Physician

/Medical

Examiner

27

1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.

21215-0036

Maryland

Baltimore,

the Maryland

/Medical

Director

Funeral

2

Completed

Be

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Exami IF FEMALE: 23b. Was decedent pregnant 1 ☐Yes 2 ☑No 9 ☐ Unknowr 1∐Yes 2∐ No

25. Was case referred to medical examiner?

1 Natural 2 Accident 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) APRIL 29, 2009

VERONICA ROLIM SALÉS FERNANDES

Newonica Rollin Sal- Hundr, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, BALTI MORE, MARYLAND 21225, 3001 SHANOUER STREET

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Box 68760, P.0. of Vital Records, Division

completely filled in by the funeral al or Attending P after death. I Director: After within 24 hours a

To the Funeral C Hospital

19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of ceptifier

determined

and manner stated.

29c. License number 223

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dundalk 2112 Scott

Day, Year) State Registrar

4 Homicide

Figistrac's Signature 32.

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Apri 1:30 PM 2669 benjamin 30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Timore 9. Birthplace (State or Foreign Country) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 68 Yrs. **Funeral** Year) 1 \ M 2 □ F Months Days Hours Min. 0 215-40-97 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 ☐Yes 2 ☐ No Director nole 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2500 2/0 Funeral 12. Was Decedent Ever in Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ A6 Specify. ð a 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "n r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be enamin 19b. Mailing Address (Street and Number or Rural Route Number, Informant's Name/Relationship City or Town, State, Zip Code) Print) Department of Health a Important: If Item 27 is any Injury or other tra once. Health a buts Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 100 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility do Approximate Interval Between Onset and Death such as 7 rdiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on extin line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) P.O. 1 Tyes 2 No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has be irector, page 2 sl autopsy performe 1∐Yes 2⊠No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 🖺 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: / 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		4	_ FOr	artment of Health and Menta rtificate of Death	2000 11222
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Dat	Reg. No. 2 U U 9 4 3 2 3 e of Death 3. Time of Death
	Physicia		John DiCocco	Apri	11 30, 2009 09:30 A M
200	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1			1402 Bonnett Place	Bel Air	Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 F 88 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. Sept	9. Birthplace (State or Foreign Country) 1. 27, 1920 1. 27, 1920 1. 27, 1920
			Usual Residence of Decedent		
	arylan show	Ē	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits 1 □Yes 2 No
	he Ma 28a-f	ectc	Maryland Harford Bel Air 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death with the Maryland ems 23a or 28a-f show r must be notified at	Funeral Director	1402 Bonnett Place	21015	U.S.A.
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	s or No- 14. Race - American Indian,
36	s after , or ite	y Fu	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give	1 ☐ Yes 2 🛣 No Specify:	Specify: White
9	hours sales	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
215	hin 72 e. an "na Media	plet	(Specify only highest grade completed) (Given life.	e kind of work done during most of working DO NOT use retired)	Dath Jahan Ghaal
2	ed wit lygien ner th	Con	3 Stee	lworker	Bethlehem Steel Middle, Maiden Surname)
Maryland 21215-0036	l be fil intal H ed ott	Be	17. Father's Name (First, Middle, Last) Michael DiCocco	Irene DiCarl	
ary!	should nd Me mark mark	ျှ		ing Address (Street and Number or Rural Route	
N N	und 2 ; alth a 1 27 Is er trau		Albert DiCocco 502	Weatherby Rd. Bel Air	, Maryland 21015
ore	es 1 a of He if item		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposerery, creation, creating the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of th	osition (Name of Date ematory or other place)	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Oaklawn		Baltimore, Maryland
Bal	permi Depar Impor any ir			22. Name and Address of Facility vans Funeral Chapel & Crem 3. Newport Drive, Forest Hil	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ilmentia	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a con ≫ uence of):		•
		ē	Sequentially list conditions, if any, leading to immediate		
W	cuted hd ransit	Examiner	Sequentially list conditions, if any, heading to financial state cause. Enter Underlying Cause (Disease or injury that initiated events C.		
Ö,	cate be executed physician and the burial-transit	ш	resulting in death) Last . Due to (or as a consequence of):		
9228		dical	d		
Box 6	death certific e attending p d for use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
	e death he atte ed for	Completed by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 1 □ Inknown	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.0	w requires that the desired speen signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	Ge. Did tobacco use contribute to the cause of death?
Vital Records,	uires t signe Id be c	d by	Unantersia ?	,	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Ö	law req as beer 2 shou	lete	00	24	4a. Was an 24b. Were autopsy findings available
R	sician: The law certificate has be irector, page 2 si	d mo:		1	autopsy prior to completion of cause of death? □ Yes 2 No 1 □ Yes 2 □ No
/ita	cian; ertifica ector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec	
of \	Physician; this certific ral director,		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		Residence 6 Other (Specify)
o	Attending r death. sctor: After oy the funer	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at 28d. D Work? M 1 □ Yes 2 □ No	escribe now injury escence
Division of	Atter ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Lc	ocation (Street and Number or Rural Route Number, ity or Town, State)
	ital or Irs afte ral Dii lled in	Cer			
0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and di investigation, in my opinion, death occurred at t	the time, date and place, and due to the cause(s)
1	To th Withir To th COMP	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Juphu & maldons	H40583	3/1109
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Judge Rol An Mi	1 DOK
	Sta	te	31. Date filed (Month, Day, Year) 33 Registrar's Signature	or victivo sugari con	, viril
1	Regist	ar	MAY 0 5 2009 Certur B. Sa	ale	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45A^M 2009 May Muriel Viola Dunlop /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia

Voar | If Under 24 Hrs. Howard Lorien Nursing & Rehabilitation Ctr 8. Date of Birth (Month, Day, Year) Oct 1,1912 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 X F 385-48-5083 96 Canada **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Expositer must be notified at 1 ☐ Yes 2▼ No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 |6336 Cedar Lane Canada Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White ð ¾☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Violin Teacher Music is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William John Hillyer Rachel Rebecca Wass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Heather Williams, Daughter 10822 Braeburn Road Columbia, Maryland 21044 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/04/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee ²² Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mouths /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Yes 2 No 9 Unknown in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 🗴 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? perform. 2 🗆 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Accident 5 Pending 1 ☐ Yes 2 🗌 No investigation within 24 hours after deatl To the Funeral Director: 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) #103 Columbia MD Cedarlane 31. Date filed (Month, Day, 32. Registrar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>009</u> Month 30 April 6:30P ANNA THERESA ANELLO DISTEFANO 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County 6003 Huntridge Road, #3522 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 17, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Months Days 1 □ M 2 🔯 F Dec 1919 Maryland 89 212-16-9931 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore County Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21210 6003 Huntridge Road, #3522 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Apera Anello Theresa John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6003 Huntridge Road, #3522, #3522, Baltimore, MD Joanne D. Mazzie (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Green Mount Crematory 5/4/2009 15 ☐ Other (Specify) 4 ☐ Donation 21. Signatur of Funeral Service Liter e

Martin D. Lawson MIICHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 MITCHELL-WIEDEFELD FUNERAL HOME,

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprinter mast be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only		Mass		interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Neto ten ten ten ten ten ten ten ten ten ten	d and Neck Con	ver	6 mon Ms
Sequentially list conditions,	b. Due to (or as a consequence of):			
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed 1 □ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical		26. Place of De	eath (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred
3 Suicide 6 Could not be determined		treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Pr (Check only one)	nysician: To the best of my knowledge, dea niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plan nvestigation, in my opinion, death occ	ce, and due to the caus- curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

State

Registrar

6569 N. Charles Street, CPW Ste 407, Baltimore, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Ha, M.D.,

MAY 0 5 2009

31. Date filed (Month, Day, Year)

D0063783 May 1,

09-03364 John Wayne Estep

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ease Type or Print in Black Indelible Ink. Ensure All Copie and \$ State of Maryland / Department of Health and Mental H	lygiene	20	09 143	26
Certificate of Death	Reg. No.			
	2. Date of Death		3. Time of Death	

i wayne Lot	1	- For St		Certificate of Death										Reg. No.	3. Time of Death				
Physicia lical Examir	n/	Registra 1. Dece	dent's Name (Fin			NI	E	STE	P					Date of De Month April 26,	2009	Yea	r	1714	
ai Exami			lity Name (if not athbound 1-4	institution,	give stre	et and num			4	b. City, Tov Largo	wn, or Lo				F	c. County or Prince G	Seorge'		
Funeral Director		5 Socia	Security Numb	er 6	. Sex		7. Age (In y	rrs. last bir	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of			Froteial	nplace (S n ntry) /	
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene. In an and Mental Hygiene. In a 71 is marked other than "natural", or items 23a or 28a-f show any aumaite event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual F 10a. St 10a. St 11. Ma 1 X 3 15. D Eler	desidence of Deretate 10b reet and Number 11	cedent County County May May May Divocation (Specary (0-12) St. Middle, J. E. William Cremation Cremation Cremation	rried 12 1	Was Decider of Armed For Yes See Green College (1	edent Ever proces? 2 X r de complete 4 or 5+)	13 M2 (7-21) (in U.S. No	13. Walfry 1 Deceder during m	10f. Zip C 10f. Zip C 2 / s Decedences, specify Yes 2 / it's Usual C oost of work g Address	it of Hisp Cuban, X No Occupation (Street	Mexican, specify: on (Give I) DO NOT 1/E/3 8.Mother t and Nun 2// //	sind of we use retire	ork done ed)	No-	14. Race White Specify: Kind of B City or To MISSING.	hat Country S A B - Americae, etc. BL usiness/II s po e)	10d. Ins 1 X Try? can India A C Trown, 2	an, Black, A Tion(
Baltimore, definite pages and permit. Pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages 1 at pages		23a. I Imme or co	Donation 5 gnature of Fune Part I. Enter the ailure. List only diate Cause (Fine indition resulting entially list conce	disease, or one cause in death)	complication each	tions that of line. Ultiple In e to (or as	caused the	death. Do	1/6	7260	1-0,	16 F0	Bet	Kel	1/5	5501	1. 1791	App	O 7 9 4 roximate Interval ween Onset and Death
Box 68760, re death certificate be executed the attending physician and	Modic	IF FE	r, leading to imme. Enter Underly asse or injury the ts resulting in de UNPENDED MALE: Was decedent posst 12 months?	ving Cause t initiated tath) Last	c. Du d	e to (or as AMENDED 23c. If yes 1 Live 4 Pres	a consequence, outcome a birth	of pregnal	2	Fetal death		Ecto	pic pregn	nancy		23d. Date Month		ery Day	Year
cords, P.O. law requires that the has been signed by	Pr.		Yes 2 No		itions o		to death b	out not rest	ulting in the	e underlyir	ng cause	given in	Part I.	24a		2 No 24	3 P	autopsy to compl	ause of death? 4 Unknown findings available etion of cause of 2 No
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n of Viding Physi h. After this		27. 0 1	Manner of Death		ending	28a. Da Apr 2	ate of Injury onth Day Yes 6, 2009		28b. Time 1704 hrs		1	Yes 2		Subject	t moto nt	rcyclist	involve		notor vehicle
VISIO or Atten fler deatl Director	in by the I	Certification:	✓ Accident Suicide	6 C	vestigatio ould not b	e 28e. P	lace of Inju			treet, facto	ory, office	e building	, etc.	28f. Loc or	ation (St Fown, Sta bund I-4	reet and N ate) 95 at Are	umber o	r Rural F e, Largo	Route Number, City o, MD
E 00			Homicide Certifier		Physicia		best of my			ccurred at t	the time,	date and	place, a	and due to to	ne cause	(s) and ma	nner as	stated.	
To the Yorkhirm	completely	ਹ	. Signature and			and manne	er stated.		Δ		29c. Lice	ense numl		OCME		29d. Date	signea	(мопіп,	Day, Year)
		30.	Name and addr Theodore M	ess of pers	on who c	ompleted Assi	cause of delistant Me	eath (Item edical E	23a) xamine	111	Penn	Street,	Baltim	ore, MD	21201				
	Sta	ate 31.	Date filed (Mon	th, Day, Ye	ar)	12	. Registrar		re -										
	gist	rar	MA	Y 05	2009	_Se	neva	<u> </u>		NAI			<u> </u>						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 200⁹ar **Physician** 6:55 P. M 27, Emala Lillian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air Upper Chesapeake Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🔀 F 1916 Maryland Nov. **Director** 219-03-2012 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 3 No Director Harford Maryland Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21085 1406 Joppa Forest Drive Apt. R Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√2√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes StNo Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced ltimołe, Maryland 21215-00 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon Assistant Manager 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Lillian Smith Edward Beatty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 1406 Joppa Forest Dr. Apt. R. Joppa, MD 21085 Eleanor Weiss / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition May Pate Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel Air 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only on Aortic Immediate Cause (Final disease or condition resulting in death) bd cominal **Physician** 2 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, reading to indirect late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Imala, Lillian M80049702 Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ∐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier D350/2 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m & 500 upper Chesapeake Dr. Bel Aig MO 21014 LYNEH Kevin Registrar's Signatur 31. Date filed (Mônth, Day, Year) State 0 5 2009 Registrar

09-03487 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elmer William Fisher State of Maryland / Department of Health and Mental Hygiene 2009 14328 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 30, 2009 ELMER FISHER Medical Examiner WILLIAM 1744 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7920 Gilmore Avenue Rosedale **Baltimore County** 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Foreign Country) NEW JERSEY Months Hours Days Director 146 42 6957 1 XM 2 60 9/22/1948 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show MD BALTIMORE ROSEDALE 1 Yes 2 X No tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 GILMORE AVENUE 21237 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Married Yes If Yes, Give Year VIEINAM 4 X Divorced Widowed Yes 2 X No specify: Specify: WHITE à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 RIDE SUPERVISOR 8 CARNIVAL ATTRACTION of Health and Mental Hygiene. If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) **JAMES** FISHER Be **JEANETTE** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 ٥ 19a. Informant's Name/Relationship (Type, Print) ROBERT FISHER/SON 601 CHAPEL HEIGHT DR. HARVE De GRACE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 5/4/09 BALTIMORE, MD Donation 5 Other Specify: 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical ending physician use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Alcohol Abuse Yes 2 No 3 Probably 4 ✔ Unknown Completed peen a page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner Hospital: 1 Other: Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 Yes No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 V Natural 1 Yes 2 No within 24 hours after death. Pending filled in by the Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town State) determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 1, 2009

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

DOME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Patricia Aronica-Pollak MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Mary Ellen Furst 30 April 2009 2:55 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris Hospice 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 13 1948 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. Months 1 M 2 Q 216-44-1919 61 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 12 Cardor Ct. #101 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Administrative Asst. n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Dukes Joseph Bacon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Girdwood Rd., Timonium, MD 21093 <u>Julie F. Maloney/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, MD Atlantic Crematory 5/1/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 0 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Lice Michael 💝: Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final

attending physician and for use as the burial-tran certificate has been signed by the a rector, page 2 should be detached in P.0. of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Funeral

Director

Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be inclined at gones. Once.

Physician /Medical Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

	disease or condition	LUNG CANCER					
	resulting in death)	Due to (or as a consequence	ce of):				
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Initiny	Due to (or as a consequence	ce of):				
ical Exar	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	ath 3 Ectopic p			23d. Date of de Month	elivery Day Year
by Ph	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying o	ause given in Part I.	23e. Did tobacc		to the cause of death?
eted					-		
Somple					24a. Was an autopsy performed? 1 ☐ Yes 2 X	prior to death?	utopsy findings available completion of cause of successions 2 \square No
Be (25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 ☐ D0	OA Other: 4 I Nursing I	Home 5 ☐ Residence	6 X]Other (Spe	ecify) HOSPICE
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory	, office	28f. Location (Street City or Town, Sta	and Number or Rate)	Bural Route Number,
dical (29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examination one X Nurse Practi	sician: To the best of my knowled ner: On the basis of examination Lionermer stated.	dge, death occurred and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner a and place, and du	as stated. le to the cause(s)
Me	29b. Signature and title of certifier	KNP	29	c. License number B149792	29d. I	Date signed (Mon	oth, Day, Year)
	30. Name and address of person who co						•
	JACKIE JONES, CRN			D. TIMONIUM	1, MD 21093		
e ar	31. Date filed (Month, Day, Year) MAY 0 5 200	32. Registrar's Signature	parker	•			

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State

Registrar

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P.O.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Alfred Ford 3,2009 6:25 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frankford Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec . 2, 1926 Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 → M 2 □ F Hours 225 24 7858 82 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1√2 Yes 2 No MD n/a Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 1006 N. Washington St. 10f. Zip Code 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I⊠Yes 2 □ No fYes, Give Never Married 2 Married 1 Tyes 2 No Baltimore, Maryland 21215-0036 Specify: black Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Bugle Laundry laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Ford Dorothy မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Branch (neice) 717 N. Milton Ave. Balto, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory May 8,200 Balto, Md. 20c. Location - City or Town, State 20a. Method of Disposition Signature of Funeral Service Licensee 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Calivin B. Struggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused re shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Deventia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Completed by Physician/Medical as the IF FEMALE use yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) ☐Yes 2☐No detached the 9 [] Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 XNo Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certil

31. Date filed (Month, Day, Year)

1 toward

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

My

29c. License number

0 43386

Ectaw

Place

29d. Date signed (Month, Day, Year)

21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 1. Deceder Physician lou /Medical County of Deat 4b. City/ Town, or Location of Death 4a. Facility Name (If pot institution, give Examiner HIMORE If Under 24 Hrs. (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 6. Sex .7. Age **Funeral** Days Min Months 1 M 2 11 Director Usual Residence of Decedent 10c. City, Town or Vocation Od Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 12. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★6
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any injury or other traumatic event, the Medical Exa 16a. Decedent's Usual Occupation Kind of Business/I Jus 15. Decedent's Education (Specify only highest grade completed) kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ax ၉ Çity or Town, State, Zip Code) 1)a. Informant's Name/Relationship 19b. Mailing Address (Street and Mumber or Rural Route (d 21225 City or Town, State 30a. Method of Disposition
1 Deurin 2 Cremation Dat 20b. Place of Disposition (Name of cerhetery, gramatory or other place) 20g Location 3 Removal from State 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. EREBROVASCU Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown signed b I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions ntributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been si rector, page 2 should ! Be Completed ONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only Tottle and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

IASNEEM

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHANI

2835

SMITH

SUITE 283.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** 5:35 AM Elizabeth Belknap Green Мау 4, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0 3 /07/ 1 926 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Days Hours 17-24-028 1 □ M 2 🖾 F 83 Baltimore, MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 11 a Medical Exp. Linet Tourit be resiffed and once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore Baltimore 1 ☐ Yes 2 XNo Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 6 Over Ridge Ct. Apt. 3921 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: Specify: White 9 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry
Boy Scouts of 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Cole Robert S. Belknap ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 101 Ridgewood Rd. Baltimore, MD 21210 Robert Green/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel – Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/05/09 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Evansfuneral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt tailure. List only one cause on each line. 16924 York Rd. Mankton, MD. 21111 Approximate Interval Between Onset and Death In mer ate Cause (Final de or condition resulting in death) eloma month **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t i be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy Physician: The certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \((Specify) \) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of of rtifier N. Charles St. Balto. son who con leted cause of death (fem 3a) (Type, Print) 30. Name an address of per Bm

State Registrar 32. Registrar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 30, 2009 3:30 A. M Howard Lloyd Graves 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford County Bel Air Upper Chesapeake Medical Center 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 XM 2 ☐ F Elmira, N.Y. 108-05-0993 91 June 11, 1917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Bel Air Maryland Harford County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21015 1304 J. Scottsdale Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Piper Air Craft Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Jewel Howard Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print Florence Graves (Wife) 1304 J. Scottsdale Drive, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

May 1, 2009

Date
20c. Location - City or Town, State
Forest Hill, Maryland 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 3 Newport Drive, Forest Hill, Maryland 21050 aw or 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RleeD INTERCECEBER Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine analocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25 Yes MIGHT 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 2 ER/Outpatient 3 DOA Impatient 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anee.

72 hours after death with the Maryland

be executed the attending physician and thed for use as the burlal-tran has been signed by the je 2 should be detached page

After

filled in by the

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A

Certification:

Medical

Howard Mfc0364855 or Vital Records, P.O. Box 68760,

Division

Examiner Physician/Medical certificate funeral director, P this

3 Completed Be

25. Was case referred to medical examiner' 1 ☐ Yes 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

4 Homicide (Check only

28a

6 ☐ Could not be

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and manner stated.

Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MacPhail Rd. Suite 106 Bel AIC, MD

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:04KM Alice Gates May 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 20, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min. Country) On10 281-07-8364 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother traumatic event, I'm Modical Exerting 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother 1 at 10 cother Director 1 ☐ Yes 2√2 No Maryland Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21036 14269 Triadelphia Mill Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏖 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Viola Omen Roy Van Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13366 Grinstead Ct. Sykesville, Maryland 21784 Johanna J. McKelvey, Daughter permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/02/09 Baltimore, Maryland 21. Signature of Juneral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Atherosclerotic Cardiovascular Disease rears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) Physician: The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certifica e funeral director, r 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

State Registrar

29b. Signature and title of ce

31. Date filed (Month, Bay, Year)

Randal Riesett MD

5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NO

29c. License number

18700 charter Brive Columbia

V58747

2009

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month May 2009

2:40 P.

4c. County of Death

Physician	
/Medical	
Examiner	

1 - For State Registrar

Sanuel William Green Sr.

Funeral Director

28a-f show traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, If a Medical Expeditor interface. Once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached Records, Division of Vital n 24 hours after death.

Funeral Director: A sletely filled in by the fu

4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Seansons Hospice Randallstown er 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month Day Year) Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 214-82-9635 1 M 2 □ F 45 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1√Yes 2□No Director n/a Baltimore M 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2807 E. Biddle Street 21213 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Specify. African-American 1 Never Married 2 Married 1 □Yes 2 No Specify ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert H. Green Sr. Edith E. Hardy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edith E. Green/ Mother 2807 E. Biddle Street, Baltimore, MD 21213 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Hardy Cenetery 5-8-09 Lawrenceville, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Sign, tyre of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-stolate Cardiomy openhu disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an was autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □W 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0057465 asap arsemo 25 Main St. JSNYE ZOO, Reisterstown, MD. 21136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Kajapakse MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAY 0 5 2009

To the I within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 30 2:36 A M John 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Ocean Pines 710 Ocean Parkway If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 M M 2 □ F 213-30-1301 Aug. 9, Maryland 1932 76 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must by motified at 1 ☐Yes 2X No Director Maryland Ocean Pines Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 710 Ocean Parkway Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1954-56 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Defense Legal Councel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabel Wilson John F. Grim ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 710 Ocean Parkway; Ocean Pines, MD 21811 Wife Joan Grim 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland 5-4-2009 4 ☐ Donation 5 ☐ Other (Specify) Mt. Maria Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IELOFIBROSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the ling I, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending properties for use as use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) o s been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

Jimmy D. Taylor MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 02928

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

200

100 E. Carroll St., Salisbury, MD 21801 32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Physician /Medical

Examiner

Funeral

Director

Alex

31. Date filed (Month, Day, Year) MAY 0 5 2009

Be Completed by Funeral Director

ဥ

Examiner

Medical Certification: To Be Completed by Physician/Medical

Please 1	Type or Print					-		gible.	
For State Registrar	State of Mary			nt of Healt te of Deal		, -	ene g. No. 2	009	14338
1. Decedent's Name (First, Middle, Last,	_	_				Date of Death Month	Day	Year	3. Time of Death
	R. Gerick	.e	Ab City	Town or Locati	en of Death	AMIZIL	29	2009 Inty of Dea	
a. Facility Name (If not institution, give		4 CENTON	46. City.	Town, or Location	TIME	KE-	40. 000	inty of Dea	ui
. Social Security Number 6. Sec	x 7. Age (/	n yrs. last birthday)	If Unde	r 1 Year If Un	der 24 Hrs.	8. Date of Birth	Year)	9. Bir	thplace (State or Foreign
12 1123	^{□ M} X (X) 6	7 Yrs.	MOUTUS	Days	IS WIIII.	Feb 28	194	2 Ma	ryland
Jsual Residence of Decedent 0a. State 10b. County		oc. City, Town or Lo							10d. Inside City Limits
MD Balti	more	Balti				T			1XX es 2 No
Oe. Street and Number 3744 Elmley	Avenue		10f. Zi	2121	3	10	g. Citizen	of What Co	•
1. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Was Dece	edent of Hispanic ecify Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit	erican Indian, e. etc.
1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		1 □Yes			. ,		ecify: W	
15. Decedent's Edu (Specify only highest grad	cation			ual Occupation ork done during r	nost of worki		6b. Kind o	of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	DO NOT L	use retired)	or work				
. Father's Name (First, Middle, Last)		H	omen	naker	other's Name	e (First, Middle, M.		n Hol	me
Roger Barnes						ice Marc			
9a. Informant's Name/Relationship (Ty exander Gerick						al Route Number,			
Da. Method of Disposition		20b. Place of Dispo		· · · · · · · · · · · · · · · · · · ·	,				Town, State
1 ☐ Burial 2 ☆ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	sayview	natory`or	other place)	!		_		e, MD
. Signature of Funeral Service Licens	ee Panella	16 C	. Name a	and Address of Fa	neral	00 Mace Home	Ave of E	nue l	Balto. MD 21221
Ba. Part 1. Enter the disease, or condi- shock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not ent	er the mo	de of dying, such	n as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
nmediate Cause (Final isease or condition esulting in death)	a. COVOI	omyo	pai	Thy		c dise			UNKNOW
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equentially list conditions, any, leading to immediate suse. Enter Underlying	Due to (or as a co			-		-			7700-
ause (Disease or injury lat initiated events	c								
esulting in death) Last	Due to (or as a co	onsequence of):							
	d								
F FEMALE:	23c. If yes, outcome of p	pregnancy					004	Data of da	diver.
3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2 L 4 Pregnant at tin 9 Unknown	Fetal death 3	Ctopic Other (s	pregnancy specify)	-		230	. Date of de Month	Day Year
art II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlvina	cause given in Pa	art I.	23e. Did toba	acco use	contribute t	o the cause of death?
v	Ü	3	, ,	v		1 ☐ Ye:	s 2 🗆 N	lo 3□F	robably 4 Unknown
						24a. Was an	2	4h Wara a	utoney findings available
						autopsy perform	ed?	death	utopsy findings available completion of cause of
5. Was case referred to medical				26 🗖	lace of Deat	1 Yes 2 h (Check only one	□No □	1 ☐Ye	s 2 No
examiner?	Hospital: 1 ☐ Inpatient	2 MER/Outpatier	nt 3 🗆 D	Othor		me 5 Reside		Other (Sp.	ecify)
. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yo	28b. Time of		28c. Injury at Work?		28d. Describe how			
2 Accident investigation			М	1 □ Yes 2	2 □No				
3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factor	ry, office		28f. Location (Str. City or Town,	eet and N State)	umber or F	lural Route Number,
	sician: To the best of r iner: On the basis of ex and manner stated	amination and/or in							
9b. Signature and title of certifier	manner ordine	*	29	9c. License numb	per	29	d. Date si	igned (Mon	th, Day, Year)
Lauren	TAhas	guo, M	DI	1006	721	00	mai	14.	2009
0. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type,	Print)		,,,,,,			RA-	more, m.
Lauren T.	Shapir	Omb.	4	940 ET	95182	N ALGA	VET	11-4	2/224
Date filed (Month, Day, Year) MAY 0 5 2009	32. Registrar's	gnaturgave	1						

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 17:10 PM Medge 2000 Mar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours 218-44-8665 February 2, 1947 Virginia **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examination unstitled at 1 ☐ Yes 2 ☐ No Directo Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 7019 Sollers Point Road 21222 Funeral death v 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White <u>\$</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 years Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie Brooks Morris Gilliam II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband 7019 Sollers Point Road, Dundalk, Maryland 21222 Douglas Gulledge 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7,2009 Oak Lawn Cemetery Dundalk, Maryland 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Maryland 21222 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PEA arrest days disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 days Examiner exacerba Sequentially list conditions, Dug to for es a consociience off Examiner than, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has i page 2 s autopsy certificate 1 □ Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death.

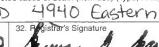
To the Funeral Director: After this certific completely filled in by the funeral director, the

> State Registrar

Risen 31. Date filed (Month, Day, Year)

Sarah

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue Baltimore, MD gark

29c. License number

RES - 00 C

29d. Date signed (Month, Day, Year)

		Registrar	se Type or Prir mend PI lin em 23a per		Certificate of	Death		Reg. No.	3. Time of Death
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Examine Funeral Director	ner		lealth Care	e Susten je (In yn: last birtho	n Perru	If Under 24 Hrs.	8. Date of Birt (Month, Da	ay, Year)	Birthplace (State or Forei Country)
D.		Usual Residence of Decedent 10a. State 10b. County		91 10c. City, Town o	r Location		Feb 2	24, 1918	Virginia 10d. Inside City Limi
the Mary 28a-f sh notified	Director	Maryland 10e. Street and Number	N/A		10f. Zip Code	Baltimore		10g. Citizen of What	1 XYes 2 1
h with 23a ol ist be	a D	5706 Narcissus Aven	nue			21215		ι	J.S.A.
d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	I If Yes, Give	Ever in U.S. No 1941	13. Was Decedent of If Yes, specify Cub		ecify Yes or No Rican, etc.)	14. Race - A Black, W Specify:	American Indian, Vhite, etc.
hours tural";		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1946	ecedent's Usual Occu	pation		16b. Kind of Busine	
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2 should be filed within h and Mental Hygiene. Fis marked other than traumatic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle, La	ast)	l	-	18. Mother's Name		, Maiden Surname)	
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d 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationshi Delores Gwynn	ip (Type. Print)	19b. N	Mailing Address (Stree 5706 Narcissu			-	ite, Zip Code)
of Heal		20a. Method of Disposition	_	20b. Place of D	isposition (Name of crematory or other pla		Date	20c. Location - City	y or Town, State
permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		1 □ Maurial 2 □ Cremation 3 4 □ Denation 5 □ Other (Spe	ecify)		Forest Veterar	ns Cemetery	04/21/09	Owing	gs Mills, Md.
permi Depal Impol any fr	h d	21. Signature of Funeral Service Li	lognsee	(10)		•	10	D 4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 8:37 P M 30, April Jeanine Pierrette Grumley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🖺 F Months Days Hours Director 74 213-66**-**7692 Apr. 13, 1935 France Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21014 130 West Belcrest Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced White Maryland 21215-00 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within and the filed within and Mental Hygiene.

Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Jean (unk) Ruffet _(unk)_Canen Renee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 Choice St., Bel Air, MD 21014 Christa S. Egerland / Friend permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Maryland (unk) 21. Signature of Funeral Service McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final disease or condition resulting in death) acute **Physician** myocardia /Medical Due to (or as a consequence of): Examiner 5 minutes SUSTOL Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transit neumonia Due to (or as a consequence of): law requires that the death certificate be Physician/Medical Branchitis as the for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 5 Other (specify) the o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an was autopsy performed?
Yes 2 X No this certificate Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of ce tifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

30. Name and address of person w

31. Date filed (Month, Day, Year)

Bharat

ratek

MAY 05

1908 Harford Rd

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-03428 State of Maryland / Department of Health and Mental Hygiene Derek Gatton 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 28, 2009 Medical Examiner Derek Wayne Gatton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore St. Agnes Hospital If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 29 1 X_{M 2} F Director 213-02-5312 Usual Residence of Decedent 10c. City, Town or Location any 10a. State Baltimore MD Baltimore 28a-f show or items 23a or 28a-f shor must be notified at once. death with the Maryland Director 10f. Zip Code 10e, Street and Number 21227 2312 Smith Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after de riment of Health and Mental Hygiene.
Thatt: If item 27 is marked other than "natural", or yor other transmatic event, the Medical Examiner mu Yes 2 X No specify: 4 X Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Glass Glazier 12 17. Father's Name (First, Middle, Last) Be Edward Joseph Gatton 19a, Informant's Name/Relationship (Type, Print) Deloris A. Combs - Mother 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Itimore, West Arunder 5-4-2009 partment c Crematory Other Specify ä Sign ture of Funeral Service Lices ee **Physician** failure. List only one cause on each line /Medical a. Hanging Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause Dispessor injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the :Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ð Completed 24a. Was an autopsy performed? 26.Place of Death (Check only one) r Attending Physician: 25. Was case referred to medical of Vital director Be Hospital: 1 Other₄ 2 Y ER/Outpatient 3 Nursing Home 5 Inpatient † ဥ 1 Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27 Manner of Death FOUND: Division Natural Yes 2 V No the f Pending death Apr 28, 2009 2100 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be determined (Specify) Garage 4 Homicide

4c. County of Death N/A If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland Jul. 18, 1979 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Beltway Glass 18.Mother's Name (First, Middle, Maiden Surname Deloris Ann Canterbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2312 Smith Avenue, Baltimore, MD 21227 20c. Location - City or Town, State Odenton, Maryland 22 Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 29d. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes Yes 2 ✓ No Residence 6 Other 28d. Describe how injury occurred Certification: Subject hanged self 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2312 Smith Avenue, Halethorpe, MD the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

2136 hrs

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f Heal f Heal ftem 2 other		Carol A. Gunther (Daughter) 20a. Method of Disposition 20b. [Place of Dispo	Urlrtwood osition (Name of matory or other place	l Court,	oppa_Mar	ytand 210 c. Location - City o	r Town, State		
Pages nent o int: If					em Grdns 5	5/8/09 T	imonium,	Maryland		
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important if filem 27 is marked other than "in any injury or other traumatic event, the once.		21. Signature of Funeral Service licenses	M M	2. Name and Addre	SS of Facility	FUNERAL	HOME, INC			
		Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the deal	16	500 York	Road, Bal	timore.	Maryland	21093 Approximate		
Physician		shock, or heart failure. List only one cause on each line.			ey dis		,	Interval Between Onset and Death		
/Medical		disease or condition resulting in death) a. Due to (or as a consequence)		1 (61.11	7 01.	200126		- Jan-		
Examiner	_	Sequentially list conditions, b.						-		
uted I Insit	Examiner	Sequentially list conditions, list, some property of the cause. Enter Underlying Cause (Disease or injury)	uence on:							
e exect an and rrial-tra	Еха	that initiated events resulting in death) Last	quence of):							
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d								
eath certifi attending for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnant					23d. Date of d	eliverv		
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signe d be d	by	Part II. Other significant conditions contributing to death but not res	sulting in the d	indenying cause giv	en III Fait I.			Probably 4 Unknown		
w requir	lete					24a. Was an	24b. Were a	autopsy findings available		
The lav	Completed					autopsy performe	ed2 death?	completion of cause of s 2 □ No		
siclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		l ou		n (Check only one))			
Physic rthis cral dire	<u>2</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatie	nt 3 DOA	ner: 4 Nursing Ho	me 5 Residen		ecify)		
Attending Physician: r death. ector: After this certific. by the funeral director, f	tion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Wor	k? lYes 2 □ No	200. Describe non	injury occurred			
r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,		
pital o										
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or ir	nvestigation, in my	opinion, death occur	red at the time, da	te and place, and di	ue to the cause(s)		
To th Within To th Comp	Me	29b. Signature and little of pertifier		29c. Licens			d. Date signed (Mor			
		" all Anthony Kiley.	uns	100	7 997	/	V14751	2007		
Q V		30. Name and eddress of person who completed cause of death (Itel	m 23a) (Type,	Print) N-	Charl	les St.	Balto.	2009 Md 2120x		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature							
Registr		MAY 0 5 2009 Sentin B	. par	145						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2005 12:15 A^M Beverly Lilly Horton May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Blakehurst Health Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth June 11 9. Birthplace (State or Foreign **Funeral** . 1920 Connecticut 1 □ M 2 🗓 F 045-20-6683 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be neuffled at **Funeral Director** 1 ☐ Yes 2 No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1055 West Joppa Road USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married X Married Maryland 21215-0036 1 □Yes 2X No Be Completed by If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hubert Lilly Gladys May Windridge ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald P. Horton, Husband 1055 West Joppa Road Towson, Maryland 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/04/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one doce on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical ue to (or as a consequence of): Examiner zenti Sequentially list conditions, if any, leading to immediate cause. Er let Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed zheime Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 2 L 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To s after death.

I Director: After this of in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours a

State Registrar

29b. Signature and title officertifier

William 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30/ N. Charles 5+ #5

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** AM 200 Sa /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Linza 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 □ F 69 5/28/1939 Director 247-58-7418 SC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at once. Yos 2 No Funeral Director **Baltimore** Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Undercliff Court 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ SpecifyAfrican-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Meadowlands 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Issac Harris Bessie Hicklen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Under Liff Court Pikesville, Maryland 21208
Disposition /Name of Date 20c. Location - City or Town, State Carolyn Harris/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/2009 Forest Lawn Cemetery Camden, SC 21. Signature of Juneral Service Licens 22. Name and Address of Facility Wylie Funeral Hone PA of Balto. Co. 9200 Liberty Road Randalistown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arriver disease or condition resulting in death) /Medical Examiner blueding Stings Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 C Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No Division of Vital Records, P.O. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Howard J. Heim Sr. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimone Franklin So Mare <0 If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 XM 2 ☐ F 81 Jan. 24, 1928 Director 217-22-0159 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanture must be positived at MD Baltimore Essex 1 ☐ Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 303 Oberle Avenue 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?
1X Yes 2 □ No P ges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White 1 □ Yes 2 TXNo If Yes Give Specify: Completed by 3 N Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fireman Baltimore County 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William K. Heim 2 Anna M. Cvach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. P. ges 1 and 2 s
Department of Health ar
Important: If item 27 is
any injur. or other trau Donna Heim /daughter 303 Oberle Avenue Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 5/6/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave. Balto. MD em Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HNOXIC Brain disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** andiobul Monary Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner **the Hospital or Attending Physician:** The law requires that the death certificate be executed hin 24 hours after death. <u>oronaru</u> attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Matural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Il Director: A 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 within 24 hours after

To the Funeral Dire

completely filled in b

> State Registrar

29b. Signature and title

DL Ajay Beha 31. Date Wed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 Franks 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Yea **Physician** 3:00a M CARLTON R. TOM MAY 2009 HARMON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner STELLA MARIS HOSPICE BALTIMORE TIMONIUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/24/1923 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 212 20 6526 Yrs Director 86 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating without any injury or other traumatic event, the Modical Examinating must be notified at MD BALTIMORE 1 ☐ Yes 2 🔀 No ROSEDALE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 PINE GROVE AVE 21237 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ∐Yes 2 🛣 No Specify: WHITE 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MILKMAN DAIRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER Η. HARMON ANNA E. LACHOFF ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA MARTIN/STEP-DAUGHTER 11007 OLD LANDING RD KINGSVILLE, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 5/2/09 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enler the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3
 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) \(\text{HOSPICE} \) 1 ☐ Yes 2X No ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Records, Vital ō Division Hospital or Attending

Baltimore, Maryland 21215-0036

MAY

State Registrar

Medical

29a. Certifier

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

one X Nurse Practition en stated.

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Apr 500 1101 62206 0 mes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N Pal TAKOMA mon di 702162F Washin If Under 1 Year | If Under 24 Hrs. Birthplace (State of Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthdal **Funeral** 1 3 M 2 □ F Months Days Hours Director AUG. 20 1944 WASHINGTON, DC <u>578-56-0683</u> 64 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Director 1X Yes 2 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5106 WEST LANHAM DRIVE 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: BLACK Ş Q Specify 3 Widowed 4 Divorced "natural" Completed th and Mental Hygiene.
7 is marked other than "natul traumatic event, in Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ROOFER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUTH BYRD KENNETH HOLMES ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 19a. Informant's Name/Relationship (Type. Print) of Health a JUANDA JOHNSON HOLMES/WIFE 4092 WARNER AVENUE C-4 LANDOVER HILLS, MARYLAND item 27 other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page Department o Important: If any injury or once. **≒** ō 1√∏ Burial 2 ☐ Cremation 3 Removal from State FT. LINCOLN CEMETERY 4/29/2009 BRENTWOOD, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tenos client Immediate Cause (Final Physician deovasaver you no disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) $\bar{w}_{\mathcal{D}}$ The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, C attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) sbeen signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy perform 2 ZN 1 ∐Yes 2**∑**No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2∐No 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, , Yearl 1 Natural 5 Pending investigation UNK 1 ☐ Yes 2 🗖 No N 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4922 LuSalle Rd, HyaTISVIIII. determined 4 ☐ Homicide Lasalle Rd Aome Ursing 29a. Certifie 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) MIS 4203GUEENSDIRG Rd HYGTE, THE MY 20781

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician 2009 5:46 A M Edward F. Hanko, Sr. May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Olney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Hours Min. 1 XM 2 ☐ F Months Days Apr 19, 85 Director 204 12 8752 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 □Yes 2X No Director MD Clarksville Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21029 United States 13660 Highland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ЂYes 2 □ No If Yes, Give Year or Dates: 1946–49 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IBEW Local 26 Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Hanko Susan Draganovsky 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Rita R. Hanko/Wife 13660 Highland Road Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Louis Church Cem. 5-8-2009 22 Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician days disease or condition resulting in death) -Ongristiv /Medical Due to (or as a conse rence of): Examiner Sequentially list conditions if my cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transi and resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ⊡Ýes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation after death. 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier tire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

P.O. Box 68760,

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) 0 5 2009

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUZ

hysicies

1)0055694

29d. Date signed (Month, Day, Year)

State

Registrar

MAY 0 5 2009

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	/Medic Examin	_	4a. Facility Name (If not institution, given	e street and numbe	1 1		4b. City, Town,		of Death	J	4c.	County of Deat	h	
- 254			University of Mary		al Cent Age (In yrs. Ia		Baltim If Under 1 Year		24 Hrs. 8	. Date of Birt	h	N A	thplace (State o	or Foreign
	Funeral Director		214-64-7497		5 3	Yrs.	Months Days	Hours	Min.	Date of Birt Month Day 07-03	- 15°5	Co	ountry) MD	
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	f shov		MD 10b. County			timoı							1 DXYes	2 🗌 No
	r 28a-	irect	10e. Street and Number				10f. Zip Code				-	izen of What Co	ountry?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Middeal Examiner must bu notified at	Funeral Director	2002 Eagle Str				2122		ining (Cnoo	ifu Voe or No		USA 14. Race - Ame	erican Indian	
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Maryland	12 should be filed th and Mental Hyg 7 Is marked othe traumatic event,	P	Jesse	Turnag		105 Mails	ng Address (Stre			Route Numb			Zip Code) 2	1 2 2 3
Mar	nd 2 sho alth and 27 Is ma		19a. Informant's Name/Relationship Lamarr C. Har	ris-Husb	and		Eagle				re,	Mary	land	
	He He		20a. Method of Disposition	7- 1/ 0:	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other p	lace)	Da	te	20c. L	ocation - City or	r Town, State	
ii.	Page ment g ant: If ury or		X Burial 2 □ Cremation 3 I 4 □ Donation 5 □ Other (Spec		Mt.		n Cem.	i	05-08		-	nsdown		
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Lice	insele		1	2. Name and Add	Cilm	ny Wyl or St	ie Fu reet	ner Bal	tal Hor	ne P.A e. MD	21217
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Division of Vital Records,	ending eath. or: Aft he fun	Certification: To	1 Natural 5 Pending 2 Accident investigat	ion			М	1 ☐ Yes 2	1	206 1 4'	(0)	and Mountains	Rumi Bouto No	ımhor
ivis	or Att ifter de Directe in by t	rific	3 Suicide 6 Could not 4 Homicide determine	200. I lace of	of Injury - At high etc. (Special	ome, farm, s fy)	treet, factory, offi	ce	,	City or To	(Street a	and Number or ite)	nulai noute ivi	itiber,
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying	Physician: To the base	est of my kno	owledge, de	ath occurred at the	ne time, date	and place,	and due to th	ne cause	(s) and manner	as stated.	e(s)
	he Ho in 24 h he Fui pletely	Medical	(Check only 2 Medical Ex	raminer: On the bas and manne	sis of examina er stated.	ation and/or				eg at the time		Date signed (Mo		
	with To t	Σ	29b. Signature and title of certifier	nen M	ub			ense numbe				4 1, 20		
T	,		30. Name and address of person wi			m 23a) (Tvn					, , , , ,	3 . ,		
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	St	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Woyengi-Doubare Rhoda Izontimi 8:47 Ам 2009 3Õ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7207 Brook Crest Way Apt. T2Baltimore Pikesville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F 219-83-9180 0 Director 9 02/21/2009 Baltimore, MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a factor Examiner must be notified at MD Baltimore Pikesville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7207 Brook Crest Way Apt. 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charm Okiemute Steven Izontimi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 Brook Crest Way Apt.T2, Pikesville, MD 21208 CharmIzontimi/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. 05/07/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Repel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Parkville, MD 21234 att1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Innry diate Cause (Final dilease or condition resulting in death) Physician Somy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 힏 Dav Year 5 Other (specify) P.O. the detached 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 1 □Yes 2 🛛 No 2 🗆 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{\overline{M}} \) Residence \(6 \) Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Lombard, 1st Flow. Kempthorne mil 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 04 30 2009 urtis ones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Country)
MARYLAND 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 214-38-9335 69 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Multical Evert. In a sufficient once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No eral Director BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 21217 14. Race - American Indian, 13 Was Decedent of Hispanic Origin? (Specify Yes or No-Physician /Medical Examiner d ansit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trice.

E	11. Marital Status	Armed Forces?	If Yes, specify Cuba	n, Mexican, Puerto Ric	can, etc.)	Black, White, etc.			
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Be Completed by Fun	15. Decedent's Ed (Specify only highest grad	ucation 16a. College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	luring most of working - -		Kind of Business/Indu			
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	20a. Method of Disposition	cemeter)	Disposition (Name of y, crematory or other plac	e) Dat		ocation - City or Tov			
	1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			4 05/04/	2009 BA	TIMORE, D	MARYLAND		
	21. Signature of Funeral Service Licen	N. Williams	22. Name and Addres SOSEPH H. 2140 N. F	SS OF FACILITY BROWN ULTON AV	JR. FUR E, BALTII	IERAL HE MORE, MI	21217		
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do n	ot enter the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between		
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Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of		11	1	11	_		
Ē	Cause (Disease or injury that initiated events	· Ketroperi	Toreal	And /les	sentaic	Hemalo	MA.		
Ě	resulting in death) Last	Due to (or as a consequence of		101 1	1 /	. 10	11.1.		
ical		d. KespitaTory	Ailuri	2/1/ar	domyli	1.1/100	of pilure		
led	UE EENALE.			VIII O					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnanc	10 110		23d. Date of delive Month	ry Day Year		
sici	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (pecify)	CH EXAMPLE		Work			
Phy	9 Unknown			an in Dort I	23e Did tobacco	use contribute to th	e cause of death?		
by	Part II. Other significant conditions of	ontributing to death but not resulting	PROVED DE	en in Fait i.			ably 4 🔀 Unknown		
ted		M	TCATIL						
lg l		1 gest	Ukr		24a. Was an autopsy	prior to cor	psy findings available npletion of cause of		
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Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)				
	1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 A ER/Ou		4 Li Nursing Hom		6 ☐ Other (Specification)	y)		
rtification: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	(Month, Day, Year)	Fime of 28c. Injur	k?	Bd. Describe how in	ury occurred			
cati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1/1/1/10/1		Yes 2 No	PA Landian (Campa)	and Number or Rura	1 Pouts Number 2-17		
rtifi	4 Homicide determined	Zoe. Place of Interly - At Home, la	tome		City or Town, Sta	and Namber of Aura	St MO		
ပိ	200 Contifier 1 Contifutor Di	nysician: To the best of my knowledge			00).		tated.		
Medical Ce	29a. Certifier (Check only one) Check only 2 Medical Examone)	niner: On the basis of examination an and manner stated.	nd/or investigation, in my	opinion, death occurre	ed at the time, date a	and place, and due to	tne cause(s)		
Σ	29b. Signature and title of certified		29c. Licens	se number	29d. I	Date signed (Month,	Day, Year)		
	+ Whene		171	77	2	1/10/	0/		
	30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)		1	/			
	HINCOLN (OFFIE 225	Green	5+ Bac	timore	m	10215		
ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 200 40RI Catherine Mozzell Jones /Medical 4a. Facility Name (If not institution, give street and number County of Death Examiner timore GENERA If Under 1 Year | If Under 24 Hrs. 8: Date of Birth (Month, Day, Year) 06/24/1941 Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F 214-35-0513 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2121 Windsor Gorden Ln. 21207 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Black þ Maryland 21215-003(3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Fredrick Jones Margaret Cromwell ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Allen/Sister 3939 Roland Avenue, Apt. 215, Baltimore, MD 21211 timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Cremation Services 05/04/2009 | Hanover, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Arlent Cremation Services 21. Signature of Funeral Service Licenses 7522 ConnelleyDr, St.N, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 4 Unknown 1 🗌 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours a To the Funeral I

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

Registrar's Signature

dause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat **Physician** 4:50 a Sarena B. Jordan Apr 30, 2009 М /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner **Paltimore** Lorien Frankford Nursing & Rehab Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Hours Min. Months 1 M 2 F **New York** May 10, 1930 Director 076-22-9566 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Necleal Examinar must be notified at 1 Yes 2 No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 U.S.A 3829 Rexmere Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: Black ξ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Northwest Baltimore Corp. Hygiene. Community Organizer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Sadie Reynolds George Kelly ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 3829 Rexmere Road Baltimore, Maryland 21218 Shelley Glenn 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. 05/07/09 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature 🤰 Funeral Service Licen 🗸 e Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. De shock, or heart failure. List only one cause on each line. of enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached to □Yes 2□No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 No 1 ☐ Yes 1 □ Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide ō To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 90 30. Name and address of persor who completed cause of death (Item 22a) (Type, Print) 8813 BO els A C 31. Date filed (Month, Day, Year) Redistrar's Signature State Registrar

J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Mar	yland	-	artmer				Mental Hy	giene Reg. No	00	110		356
			Decedent's Name (First, II	Middle, Last)									2. Date of D	eath	-	Year	3. Time o	of Death
	Physicia /Medic		Dorothy Eli	isabetl	h Kroh		_						AMONT	L 2	8	2000	16:	40 pm
and it	Examin		4a. Facility Name (If not insti					,	1			of Death		40	. County	of Death		
	•		SAJNIT AC 5. Social Security Number	6. Sex	HOZ		In ure la	st birthday)	If Unde			ORE or 24 Hrs.	8 Date of B	rth		9. Birthp	lace (State	or Foreign
- 1	Funeral Director		212-30-9096		M 2 ∏ F	7. Age (75	Yrs.	Months	Days	Hours		(Month, E	ay, Year,	3	Coun	try)	
			Usual Residence of Deceder															Diby Limite
	arylan show	_	10a. State 10b. Co	ounty			-	Town or Lo								1	0d. Inside (1 🔀 Ye:	s 2 🗆 No
	he Ma 28a-f	Director	MD 10e. Street and Number				Бат	THOLG	10f. Zi	Code				10a. C	itizen of \	What Coun		
	with t			c Ctro	o+					230					5.A.			
	ns 20	Funeral	1450 Decatur		12. Was Dece		er in U.S	. 13.			lispanic C	rigin? (Sp	pecify Yes or No Rican, etc.)		14. Rac	e - Americ		
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinations must be notified at	by	1 ☐ Never Married 2 ☐ 3 💆 Widowed 4 ☐ Dive		Armed Fo 1 ∐Yes If Yes, Gi Year or D	² ₩ No			if Yes, spe 1 ∐Yes		Specif		Rican, etc.)			ck, White, e y: Whi		
2-0	72 ho	eted	15. Dec	edent's Educ	cation e completed)			16a. Dece	dent's Usu	al Occup	ation during mo	st of work	ing	16b. l	Kind of B	usiness/Ind	dustry	
121	ithin ne.	Completed	Elementary/Secondary (0-		College (1	1-4or 5+)		\\ Homer		se retired	d) "			Otaz	n Ho	me		
2	iled w Hygie ther t		5 17. Father's Name (First, Mi	ddle. Last)			1	пошеі	laker		18. Mot	her's Nam	e (First, Middl				unk	
ano	d be f ental ked o c eve	To Be	Witold Boro															
Mary	o ≠ 1. ≠	F	19a. Informant's Name/Rela Michael Krol					19b. Maili 262	ng Addres Mead	s (Street OW R	and Num oad ,	ber or Rui Pasa	ral Route Num idena,	ber, City	or Town, 2112	, State, Zip 2	Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Der artment of Health Important: If Item 27 I any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 🏗 Crema		emoval from	State	l ca	ace of Disponentery, cre	matany ar	other mier	rices		Date 14/2009	1		· City or To		1
Baltin	permit. Pages 1 De artment of H mportant: If Ite any injury or ot		1 Burial 2														21076	
			23a. Part 1. Enter the disease	se, or compli	cations that o	ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory											Approximation Interval B	ate etwaen
يالو	Physician		shock, or heart failure Immediate Cause (Final disease or condition	. List only or	ne cause on e			TERA	. (_	PN	FU	MAN	AT 1				Onset and	Death
	/Medical	resulting in death) Due to (or as a consequence of):														<i>DI</i>	1.	
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0.	at the dea by the ai	/sici	1 ☐ Yes 2 No 9 ☐ Unknown		4 ☐ Preg 9 ☐ Unkr		ime of de	eath 5	Other (s	pecify) _							,	
~ a .	that the ed by detac		Part II. Other significant co	onditions cor	ntributing to d	leath but	not resu	Iting in the I	ınderlying	cause giv	en in Par	t I.	23e. Did	l tobacco	use con	tribute to t	he cause o	f death?
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< ROF ecords,	The law requires that the death certificate be execute ate has been signed by the attending physician and bage 2 should be detached for use as the burial-trans	Completed											24a. Wa		24b.	Were auto	psy finding	s available
~~	The Is	mo			 ·								per 1 □ Yes	opsy formed3 2 X N	io	death?	2 No	Cause of
ita	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to m examiner?	⊢							26. Pla	ice of Dea	th (Check only	_/_				
of Vital	> .∞ ⊽	ဥ	1 ☐ Yes 2 No			npatient		ER/Outpatie			# 🗆	Nursing H	ome 5 Re				fy)	
7 5	ding Ph h. After thi funeral	ion:		Pending nvestigation	28a. Date (Mor	of Injury	Year)	28b. Time Injury	м	28c. Inju Wor	ryat rk?]Yes 2∣	□No	28d. Describ	e now inj	ury occu	rrea		
Division	l or Attend after death Director: /	ficat	3 ☐ Suicide 6 ☐ G	Could not be letermined	28e. Place	e of Injury	y - At ho	me, farm, s			1103 0		28f. Location	(Street	and Num	ber or Run	al Route N	umber,
Ö	al or / s after al Dire	Certification:	4 ☐ Homicide	eterrinied	build	ling, etc.	(Specify	′)					City or T	ʻoʻwп, Sta	ite)	_		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 12 Ce (Check only 2 Me	rtifying Phy dical Exami	ner: On the I	e best of basis of e	examinat	wledge, dea tion and/or i	th occurre nvestigation	d at the ti	ime, date opinion, d	and place death occu	e, and due to the	ne cause e, date a	(s) and n	nanner as , and due t	stated. o the cause	e(s)
	To th within To th comp	Me	29b. Signature and title of c						2	_	se numbe						Day, Year,	
			▶ DAdut	un	MD					12	36	12		AY	ril	28	200	9
_	2		30. Name and address of p	MI	MITCH	ART	0)	OD Ca	ton	AN	env	e, p	baltin	non	e , x	10	2122	-9
	Sta Registr		31. Date filed (Month, Day,	Vear) 0 5 20	32.	gistrar	Signat	ture	back	A								
			17.77	V V G	AAA I	A	-	7 S.A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May ^{Day} 2009 3, 6:30 A M Ferdinand Paul Kelly 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Howard Ellicott City Morningside House Assisted Living Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Days Min 1 (3rM 2 □ F May 18, 1918 214-03-2788 90 Maryland Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 No Catonsville <u>Maryland</u> Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 415 Oak Forest Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: WW∐ 1 Never Married 2 The Married White 1 ☐ Yes 2 🔀 No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Architect/Owner Architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel L. Crowley William J. Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 415 Oak Forest Avenue; Catonsville, MD 21228 Wife Lucille Kelly 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 5/7/2009 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Ignalure of Funeral Service Licen e-Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. onot enter the mode of dying, such as cardiac or respiratory arrest, Athen Sclentic Cardiovas (we ex DIFFERR Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ⊒Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was autopsy performed? 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence Cother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Examiner burial-transi and physician a the burial-P.O. Box 68760, certificate be attending p signed by the a Division of Vital Records, cate has been si page 2 should b this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23a

"natural",

should be filed within 7 nd Mental Hygiene.

atth and Mental Hy

permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trai

Physician

/Medical

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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other traumatic event, the Medical Examiner must be notified at

Examine Physician/Medical IF FEMALE: Certification: To

<u></u> Completed Be

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28b Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D30041 29d. Date signed (Month, Day, Year)

Jaha Dalm Kamesh 31. Date filed (Month, Day, Year)

Back RIVH NECK ROAD BELLMORE Maylard 21201 32. Registrar's Signature

201-109

State Registrar

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 2:15A M May Despina Kostaras /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 2211 Hampshire Drive Fallston If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 5-27-1923 **Director** 148-48-0636 85 Greece Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State items 23a or 28a-f show 1 ☐ Yes 2X No Director MD Harford Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 USA 2211 Hampshire Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. r than "natural", or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ∐KNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Baker Bakery 7 is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marika Unknown ပ Elias Angelis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2211 Hampshire Dr., Fallston, MD 21047 Department of Health Important: If item 27 any Injury or other trong once. 27 Maria Almiroudis-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5-6-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Demetrios Cem. 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AtheroscleRoti CARDIOU Physician 4 ear /Medical Due to (or as a consequence of) Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 DNo 1 ☐ Yes 2 🕦 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 No · this Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 □Yes 2 □ No 2 Accident 3 ☐ Suicide

Division of Vital Records, P.O. Box 68760, Co.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🐧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

d35522

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE BEL AIR MARYLAND NORT WI

State Registrar 31. Date filed (Month, Day, Year) MAY 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:25 A^M 2009 May ELIZABETH BAKER KELLEY Ph.D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GILCHRIST HOSPICE CENTER Baltimore County Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 👿 F 82 1927 212-22-9020 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Eventher must be notified at 1X Yes 2 □ No Director Maryland Baltimore City 10g. Citizen of What Country? 10e. Street and Number 21210 USA 9 Tamworth Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 1 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital Research Analyst permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerome Telfair Kelley, Sr. Mildred 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 176, Green Village, 07935 Jerome T. Kelley, Jr. (Brother) New Jersey Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 5/11/2009 Baltimore, Maryland 21. Signature of Furnal Service Licensee

Martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) physician Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. wision of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 □No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No e Hospital or Attendi 24 hours after death. e Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

32,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Kristi A. Lim 2009 6:30 P /Medical May 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛛 F Hours Min. Bedford, PA 207-52-7117 34 Director 09/05/1974 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examinator must be notified at York PA Director York 1 ☐Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17403 2041 Hollywood Parkway U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 27€ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donna Everhart Clyde Lowery ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 Hollywood Parkway, York, PA 17403 Robert W. Lim/ Husband Baltimore, Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Rose
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/07/09 York, PA 4 Donation 5 ☐ Other (Specify) nature of Funeral Service Licens Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** dis ase or condition sulting in death) Metastatic MONTL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the ending to him clat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (un se a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 Tes 3/ No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 19TION has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural in 24 hours are:
the Funeral Director: Afternately filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 of death (item 23a) (Type, Print) 30. Name and address of person who completed cause 535 Mar Gosn Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:30 A M May Patricia -oal 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Baltimore Hospita Herbor If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, APR 30, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 1934 Pennsylvania **Funeral** 1 ☐ M 2 🛛 F 184-28-1277 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County show. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 1708 Norfolk Road 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Specify.White 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Hilton Thomas W. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James B. Loar/husband 1708 Norfolk Road Glen Burnie, MD 21061 item 27 i permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/5/09 Baltimore, MD 21. Signature of Funeral Service LicenseeC. Todd Dring cremation Society of Maryland, Inc. Earl 299 Frederick Rd Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure den **Physician** /Medical Due to (or as a consequence Examiner day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of Examiner Division or Vital Records, P.O. Box 68760, imescertificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cauce/ Completed 24b. Were autopsy findings available prior to completion of cause of performed' death? 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1_Inpatient ို 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director: A rfilled in by the fu 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addres of person who completed ause of death (Item 23a) (Type (Print) 3001 South Mohinddin Schaib Baltimore, 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar		artment of F			giene Reg. No 20	09	14362
	Dhyoioi	an.	1. Decedent's Name (First, Middle	, Last)				-	2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic	al	Chang Lee				4b City Town	Location of Death	May	1 20	09	2100 M
	Examin	er	4a. Facility Name (If not institution Seasons Hospice	, give street and n	umber)			illstown	ı	40. 000111		imore
	Funeral Director		5. Social Security Number 219–15–3382.	6. Sex 11√2 M 2 □ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, D	rth av. Year)	9. Birth Cou	place (State or Foreign Intry) KOPCA
			Usual Residence of Decedent		140.0	ity. Town or Lo						10d. Inside City Limits
	f show	ō	10a. State 10b. County	ned	10c. C	Ellicot						1 ☐ Yes 2 No
	r 28a-	Director	MD HOW 10e. Street and Number	aru		ши	10f. Zip Code			10g. Citizen of		intry?
	23a o ust b	ralD	3306 Cara Court				210				USA	
336	2 should be filed within 72 hours after death with the Maryland nand Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaluation of the month of a standard of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of the month of	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F	2.27No ∂ive		Was Decedent of H fYes, specify Cuba 1 □Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Speci	ack, White, A	ican Indian, , etc. Sian
2	72 hou natura fical E	eted	15. Decedent	's Education	f)	16a. Dece	dent's Usual Occup	ation during most of wor	king	16b. Kind of E	Jusiness/I	ndustry
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Baltimore,	permit. Pages 1 and 2 should be fi Department of Health and Mental t Important: If item 27 is marked ot any injury or other traumatic even once.	-	21. Signature of Funeral Service		· Poll:	22		ss of Facility Wy	lie Funera	al Home P	.A. of	Balto. Co.
Ė			23a. Part 1. Enter the disease, or	complications that	caused the dea						,	Approximate Interval Between
	Physician	1	shock, or heart failure. List Immediate Cause (Final disease or condition	1.1	tastutic	Gastri	cana	1.			- 19	Onset and Death
1	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):	-					
	ed sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b	o (or as a conse	wence of:						
<u>,</u>	ficate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
8760,	ate be hysicia the bur			d								
39 X	certific nding p	/Мес	IF FEMALE:	23c. If yes, o	utcome of pregr	nancy			_	23d. D	ate of deli	verv
P.O. Box	the death y the atter ched for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	e birth 2 Pet egnant at time of	al death 3	∃Ectopic pregnand ∃Other (specify) _	У			onth	Day Year
ds, P	uires that n signed b id be deta	þ	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifin within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Completed							24a. Was auto perf		prior to death?	topsy findings available completion of cause of
Ita	cian: ertifica	Be C	25. Was case referre o medical examiner?					26. Place of Dea	ath (Check only	one)		
of \	Physia r this c rat dire		1 Yes 2 No 27. Manor of Death		☐ Inpatient 2 ☐ te of Injury	ER/Outpatier		er: 4 ☐ Nursing h	Home 5 ☐ Res	how injury occu	ther (Spec	attent hospile
on	nding ath. r: After e fune	ation	1 √ atural 5 ☐ Pendin 2 ☐ Accident investi	g (Mo	onth, Day, Year)	Injury	Wor	k? Yes 2. □No	254. 25551125	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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/	B Hospita 24 hours Funera etely fille	Medical C		g Physician: To the Examiner: On the and ma								
)	To the Comp	Me	29b. Signature and title of certifie				29c. Licens			29d. Date sign	ned (Month	h, Day, Year)
			nskajapalne i					005746			10%.	
			30. Name and address of person N.S. Rappak	who completed ca	use of death (Ite 5 Main St.	suite 20	Print) O, Reister	stown, M	D. 21130	Ĉo .		
	Sta		31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	. 4.1					
	Registr	ar	MAY 05	2009 12	Ensur	p. 190	arte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month. Physician 14:01PM ADY, Melvin Eugene Leek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore Lane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, May 19, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 M M 2 □ F Months Hours 212-28-5901 77 1931 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natura", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Examinate respectives at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 227 Glenrae Drive 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 🛛 No Specify. <u>≽</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Leek Virginia Maddison ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Elizabeth Leek 227 Glenrae Drive; Catonsville, MD 21228 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: once. 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 5/2/09 Woodlawn, Maryland 22. Name and Address of Facili Sterling Ashton Schwab Witzke 21. Signature of Janeral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death Part . Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Castrointestinal disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if my hading training to the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a conse uence of the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 D Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ athereseleration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No conditionascular 24a. Was an performed' 25. Was case referred to medical examiner? certificate 2 No Yes Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner states within 2 To the 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Pages 1 and 2 should nent of Health and Mer

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

eras

Agnes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Reed

Year)

31. Date filed (Month, Day,

M.D. Saint

Registrar's Signature

41543

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

		1 □ Yes	s 2 🗖 No
25. Was case referred to medical		26. Place of Death (Check onl	y one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Re	esidence 6 Other (Specify)
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	Physician: To the best of my knowledge, death occumulariner: On the basis of examination and/or investigation and manner stated.		
29b. Signature and title of certifier	1 -	29c. License number	29d. Date signed (Month, Day, Year)

State

Registrar

Medical

Ri 32 Registrar's Signature 31. Date filed (Month, Day, Year) 0 5 2009

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

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De, Print)
N. Charles St. Balto. Md 2020/2 6701

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/Medical Examiner uttending Physiclan: The law requires that the death certificate be executed P.O. Box 68760, phys the Division of Vital Records,

Physician

Physician

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event

/Medical

Director

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Physician/Medical

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within To the comple	29b. Signature and title of c	certifier	29c. License number R 0 8 7 6 2 5	29d. Date signed (Month, Day, Year)
5 ⁺¹	30. Name and address of portion of the ARCIA R. 31. Date filed (Month, Day,	erson who completed cause of death (Item 23a) (Type, Print, Soulsman NP 821 N. E. Year)	utan St. Suite mo 2120	308 BALTIMORE
Registrar	MAY 05		,	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		Please	Type or Prin				ure All Copie and Mental H		_egible.	
	-	For State Registrar	State of Ma	•	•	ite of Death		Reg. No.	2009	3 14366
Physicia	an	1. Decedent's Name (First, Middle, La	ast)				2. Date of Month	Day	Year	3. Time of Death
/Medic		Teresa Mary Lown					May 1			10:05 PM
Examin	er	4a. Facility Name (If not institution, gi Charlestown Retin	,	er		y, Town, or Location ${\sf tonsville}$		40.	County of Deat Balt.	imore
Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birth		er 1 Year If Under	24 Hrs. 8 Date of	Birth	9 Birt	hplace (State or Foreign untry)
Director		215-28-5094	1 ☐ M 2 🛣 F	89 Y	rs.	S Days Hours	Oct.	20, Year)	9 1 9 M	aryland
fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
Mary a-f sh	ctor	MD Baltin	nore			Catonsvill	e			1 □Yes 2 XNo
or 28	Director	10e. Street and Number	_		10f. 2	Lip Code		10g. Citizen of What Country?		
s 23a	eral	711 Maiden Choice	Lane 12. Was Decedent	Consider 11 C	10 Was Dag	21228		No. 14. Race - American Indian,		
fter de ritem ineri	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 N	No			rigin? (Specify Yes or n, Puerto Rican, etc.)	INO-	Black, White	e, etc.
ours a ral", o	d by	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ∐Yes	2X No Specify	•		Specify: W	hite
"natu	lete	15. Decedent's E (Specify only highest gr	Education rade completed)	1 (sual Occupation work done during mos	st of working	16b. Kir	nd of Business/	Industry
withir jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		ess Owner			Gro	cery
al Hyg othe	Be C	17. Father's Name (First, Middle, Las				18. Moth	er's Name (First, Mid		Surname)	
ould b Ment arked atic e	2	Christopher Pote					izabeth So			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparatrent of Health and Mental Hygiene. Important: I flee x718 marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the the clinal Examinar must be neithed at once.		19a. Informant's Name/Relationship Karen Smith - Da					elbyville,			Zip Code)
t of He rof He or oth		20a Method of Disposition 1 → Burial 2 → Cremation 3 □	☐ Removal from State	20b. Place of I	_		Date		cation - City or	
it. Partrumen rtant: njury		4 Donation Tother (Special Signature of Funeral Service Line	ify)	HoLy Cr		,	5-5-2009 ity Ambrose			Maryland
Depart any L		21. Signative of Funeral Samual Tree	act			ring Rd.,				
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each lir	I the death. Do no	ot enter the m	ode of dying, such as	s cardiac or respirator	y arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a Pano	realic	- 00	ncer				Onset and Death
/Medical Examiner		resulting in death)								
	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	f):					
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icate be exphysician s the burial	ledical		d							
leath certifica attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					2	23d. Date of de	livery
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death t time of death	3 ☐ Ectopic 5 ☐ Other (_	Month	Day Year
that the dened by the a	Phy	9 ☐ Unknown Part II. Other significant conditions		ut not reculting in	the underlying	regues given in Part	1 23e D	id tobacco u	se contribute to	the cause of death?
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The law ate has bage 2 s	Completed							utopsy erformed? s 2 No	prior to death? 1 □ Yes	completion of cause of
clan: ertifica ector, p	BeC	25. Was case referred to medical examiner?				26. Plac	e of Death (Check or		12,00	
Physic this c	2	1 Yes 2 No		ent 2 ER/Out					Other (Spe	ecify)
ding h. After funer	tion	27. Manner of Death 1	28a. Date of Inju (Month, Da	ry 28b. Ti y, Year) In	jury M	28c. Injury at Work?		be how injury	y occurred	
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tal or s afte al Dir	Cert	→ □ Hollicide	building, etc	(эреспу)			City or	Town, State,		
	=	29a. Certifier Certifying P	hysician: To the best	of my knowledge,	death occurr	ed at the time, date a	and place, and due to	the cause(s)	and manner a	s stated.
To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	edical	(Check only Ž☐ Medical Exa	miner: On the basis of and manner sta	r examination and	i/or investigati	on, in my opinion, de	eath occurred at the til	ne, date and	place, and due	e to the cause(s)

State Registrar It title of certifier

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16	/Medic Examin		4a. Facility Name (If not institution			744100	4b. City, Town, or	Location of		P	$\overline{}$	County of Death		
age "	LAGIIIII	•	Sinai Hospi	tal of	Baltin	nore	Balti							
ı	Funeral Director		5. Social Security Number 220-39-6683	6. Sex 1 ☐ M 2X F	7. Age (In yrs. 1.5	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min. N	Date of Bird (Month, Da DV • I	y Year	9. Birth Cou Mai	place (State or Fo ntry) Cyland	oreign
	show	jo.	Usual Residence of Decedent 10a. State 10b. County 1arylano Car	roll		y, Town or Lo	cation .nster						10d. Inside City L	
;	a or 28a-	Direc	10e. Street and Number 2728 Albert				10f. Zip Code 2.11	.57			-	en of What Cou	ntry?	
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Baltimore, Maryland 21215-0036	thin 72 hour e. an "natural"	Completed b		it's Education st grade completed		I (Give	dent's Usual Occup kind of work done of OO NOT use retired	during mos	t of working	7.5	16b. Kin	nd of Business/In	ndustry	
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bug !	ntal H	Be	17. Father's Name (First, Middle, Carl Eldredg	*	niet			18. Mothe	er's Name <i>(F</i> Chri	stine				
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Je,	item item item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	i	Date			cation - City or T		
<u>E</u> .	Page ment ant: If ury or		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State I	v Luth	neran Ce	em. M						
3alt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service	Licensee 7-4			2. Name and Addre							
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F	hysician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	each line.		failure)		-			Onset and Dea	ath _
E	/Medical Examiner		resulting in death)		(or as a conseq	uence of):	ionia						5 day	is
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3876	ncate be ey physician s the burial	dica		d										
P.O. Box 68760	eatn certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Liv	utcome of pregna birth 2 Feta gnant at time of c known	Ideath 3	☐ Ectopic pregnand ☐ Other (specify) _	:у			2	23d. Date of deli Month	very Day Yea	ar
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	io the hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (ng Physician: To t i Examiner: On the and ma										
	Vith Com	Σ	29b. Signature and title of certific	111-11	man,	NID	29c, Licens	410	. 8		10	e signed (Month	2009	
			30. Name and address of person Charlotte Glicks	who completed ca	use of death (Iter	m 23a) (Type, W - Be	Print) (vedere	Ave	Ba	ltim	ore.	Md.	11215	
	Sta		31. Date filed (Month, Day, Year,	*	Registrar's Signa	aure La	Med							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician May 3, 2009 3:25 AM JOEL STEWART LACEY, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE Social Security Number 6. Sex Baltimore County

9. Birthplace (State or Foreign Country) Timonium 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 12, 1 **Funeral** Months Days Hours Min. 218-72-0726 Director 49 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Exercities must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Baltimore County Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Whips Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 21215-0036 1 ☐Yes 21 No Specify Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Retail Restaurant is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Maryland** Be Pages 1 and 2 should be 1 ment of Health and Mental Joel Stewart Lacey, Jr. Joan Bidle or other traumatic ဥ permit. Pages 1 and 2 shoul Department of Health and M Important: If Item 27 is mari any injury or other traumatl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4018 Cloverland Drive, Phoenix, Maryland 21131 Ellen M. Benson (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Dulaney Valley Mem Grdns 5/5/09 Timonium, Maryland 21. Signature of Funéral Sérvice Licensee

Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): the attending physician a hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) \(\text{HOSPICE} \) 1 Yes 2 No 1 🗍 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State MAY 05 Registra

DHMH 17 Rev 1/2001

ORIGINAL

amend #22 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 24 09 4 1:30 AM Κ. Calvin Matthews /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 818 Argonne Dr. Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Baltimore, Md. 5. Social Security Number 0843 213-70-0483 8. Date of Birth (Month, Day, Year) 10/1/1957 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1√2 M 2□ F Months Hours 51 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, "he Medical Experiment, and be inclined at 1 Yes 2 No Director Md. N/A<u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 818 Argonne Dr S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Sa ed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin Matthews Sr. Hilda Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Mathews 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 30-09 22. Name and Address of Facility Gary Pass Balto 21. Signature Funeral Service License March Eutaw 23a. Port 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition resulting in death)

Due to (or as a construence of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of Approximate Interval Between Onset and Death **Physician** /Medical Examiner pertensive Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a ☐Yes 2☐No o. 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed this certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Powithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H4593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smoth Avenue Suite 203 BWton burah 32. Registrar's Signature State Registrar arked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ 1	For State Registrar	te of Maryland		tificate of D		R	eg. No. 2009	14370
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Naomi L. N	ladis	on		2. Date of Deat Month	Day Year A pr 29, 2009	3. Time of Death 9:00a M
A. Marie	Examin		4a. Facility Name (If not institution, give street a			4b. City, Town, or			4c. County of Death	VA
	Funeral Director		3600 West 5. Social Security Number 217-22-8373 6. Sex 1 □ M 21	Lexington Street 7. Age (In yrs. last 87	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 20	(Year) 9. Birth	nplace (State or Foreign untry) o, Carolina
	w w		Usual Residence of Decedent 10a, State 10b, County	10c. City. 7	Town or Lo	cation				10d. Inside City Limits
	Maryla -f sho	tor	Maryland Baltimore C	ity		Ва	altimore			1. XYes 2. No
	or 28a	Director	10e. Street and Number		_	10f. Zip Code		1	0g. Citizen of What Co	
	s 23a		3600 West Lexington Street		10.1	W Dans dank of Hi	21229	asifu Va a ar No	U.S	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination is neithed at once.	by Funeral	1 Never Married 2 Married 1	s Decedent Ever in U.S. ned Forces?]Yes 2 No es, Give ar or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 □Yes 2□XNo	spanic Ongin: (3p n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
215-0036	thin 72 hore. an "natur. Medical I	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work)	ing	16b. Kind of Business/I	ndustry Home
21	filed within Hygiene. other than "		12. Father's Name (First, Middle, Last)			Hom	nemaker	e (First, Middle,	Maiden Surname)	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manatic event.) Be	Charlie Jon	es			TO, MOUTOT S TRAIT		ary Jones	
aryl	should be fi and Mental H s marked of umatic ever	은	19a. Informant's Name/Relationship (Type. Pri		19b. Mailir	ng Address (Street a	and Number or Rui	al Route Numbe	r, City or Town, State, 2	(ip Code)
	1 and 2 Health a em 27 is ther tra		Daphane Willis			104 Lounsbui				
altimore,	Pages 1: ment of He ant; If iten ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	li from State		osition (Name of matory or other place on Cemetery &		05/05/09	20c. Location - City or Baltimo	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Survice Licensee	Esten		2. Name and Addres Estep B 1300 E	rothers Fune	ral Service, altimore, Mo	P. A. 121217	
	Physician /Medical Examiner	Ji.	resulting in death)	s that caused the death. See on each line. ORONARY Due to (or as a conseque)	AR nce of):		g, such as cardiac		rest,	Approximate Interval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque						
O. Box	the death cert y the attendin ched for use a	Physician/M	in the past 12 months?	ves, outcome of pregnand ☐ Live birth 2 ☐ Fetal d ☐ Pregnant at time of dea ☐ Unknown	leath 3[☐ Ectopic pregnanc	у		23d. Date of de Month	ivery Day Year
ds, P.	uires that the de signed by the d be detached to	þ	Part II. Other significant conditions contribution of TENTENSIVE CA	_			en in Part I.		obacco use contribute to res 2 □ No 3 □ P	the cause of death?
Division of Vital Records,	The ate h page	Completed						1 □Yes	prior to death?	utopsy findings available completion of cause of
Z.	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospita	al: 1 □ Inpatient 2 □ El	B/Outpatie	unt 3 🗆 DOA Oth	er: 4 \ Nursing H	-	<i>ne)</i> dence 6 □Other (Spe	ncifu)
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Divis	⊒ffe ⊒	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 286	e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (\$ City or Tov	Street and Number or R vn, State)	ural Route Number,
	the Hospital hin 24 hours a the Funeral mpletely filled	ical	29a. Certifier (Check only 2 Medical Examiner: C	on the basis of examination	ledge, dea on and/or i	th occurred at the ti	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	thin 2.	Medical	one) at 29b. Signature and title of certifier	nd manner stated.		29c. Licens			29d. Date signed (Mon	
	5 7 8 1		29b. Signature and title of certifier				59107		05-04-	
	41		30. Name and address of person who complet	ed cause of death (Item 2	23a) (Type	Print)				
	Sta	ate	31. Date filed (Month, Day, Year)	0 BUSINES 32 Registrar's Signatu	1	a del		- / ICIVY		-1176

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** 16:08 M Mamduh Maj Apri 200' /Medical 4a. Facility Name (If not institution, give street and number) 4b. Gity, Town, or Location of Death 4c. County of Death **Examiner** Medical LHIMORE If Under 24 Hrs. Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Hours Days 216-42-258 65 Director March 27, 1944 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any julyry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director MD n/a Baltimore 10f, Zip Code 10e. Street end Number 10g. Citizen of What Country? 21229 416 Edgewood Street USA 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No þ Specify: African-American 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custon Painter Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Nelson Lena Dennis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashidda Khalil/Sister 7502 Windsor Mill Road, Windsor Mill, ND 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Menorial Park 5-1-09 Woodlawn, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Şervice Licenses 5200 LibertyRoad, Randalistown, Md 21133 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhage /Medical Due to (or es a consequence of)-Examiner irrhosis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rachel Greenbera MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 5 2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2009 30, April 2:52 PM Charlotte S. Marek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium 308 Wynell Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 💢 F Yrs. 216-36-3922 Dec 18, Director 1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 308 Wynell Court 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married Maryland 21215-0036 1 □ Yes 2**X** No Specify: White Ś 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Paul Gustav Schafer Charlotte Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a tant: If item 27 is John R. Marek/husband 308 Wynell Court Timonium, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 05/02/09 Odenton, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural B Hospital or Attendi 24 hours after death. Funeral Director: # 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) |
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

32. Registrar's Signature

29c. License number

40854

Bultmore

1,2009

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:03 A^M 2009 Rembert Clay Moats /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☑ M 2 □ F Director 81 Mar. 26, 1928 Virginia 225-30-2612 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Mydical Examinar count be notified at 1 ☐ Yes 2 🔀 No Director Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21085 1811 Shirley Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō, 1 □Yes 2 No Specify: Specify: ģ White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Floyd (unk) Moats Mattie Emma Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i via Moats Wife 1811 Shirley Avenue, Joppa, MD 21085 20c. Location - City or Town, State of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Iter
any injury or oth 2 Cremat 5 □Oth Air Memorial Gdn. 5-4-09 Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 ic flons that consed in e cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. Immediate Cause (Final diseas for condition resulting in death) Toxic Mesaco/or **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and is the burial-trans Due to (or as a consequence of): 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? ☐Yes 2☐No ed by the a 9 Unknown signed by to be a signed by the detach significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ascola Disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 2,**Z** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical After this certific funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Linpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after dead To the Funeral Director 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print)

1838 Greene Tree Roa) #420 Salfmore, M) 2120

1832. Registrar's Signature factor.

State Registrar

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MK# M6000 38866

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of N	/laryland	-	artment o <i>rtificate d</i>			/lental Hy	/giene Reg. No.	711114	and the second	374
	Dharais		1. Decedent's Name (First, Middl	e, Last)						2. Date of De	eath Day	y Year	3. Time of	Death
3.	Physici /Medi		Ric	chard Reed 1	Mister					May	1	2009	6:25	A^{M}
	Examir	ner	4a. Facility Name (If not institution	-	er)		4b. City, Town		_		4c.	County of Dear		
			2919 Westchest 5. Social Security Number		Age (In yrs. la	et hirthday)	Ell:	icott	City der 24 Hrs.	R Date of Bi	rth	Baltimo	hplace (State	or Foreign
н	Funeral Director		213 60 7747	1 <u>⊠</u> M 2□F	58	Yrs.	Months Da			8. Date of Bi (Month, Di 03-08-	ay, Year) -1951	L ME	untry)	or r oreign
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	s 23a	era	2919 Westchest		A Francis III O	40.1	2104		0-1-1-0 (0-			nited St		
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2X Mari 3 □ Widowed 4 □ Divorced	ied 12. Was Deceder Armed Forces 1 X Yes 2 [If Yes, Give Year or Dates	s? ⊒No		Mas Decedent fYes, specify C I □Yes 2🛣 I			pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify:		
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Maryland	d 2 st th and 7 is n traur		19a. Informant's Name/Relations Daryl L. Miste				-					or Town, State, . City, MC		
	1 and Heal Hem 2 Hem 2		20a. Method of Disposition	ET/MTTE	20b. Pla		sition (Name or natory or other			Date		ocation - City or		
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service		M0104		ematory . Name and Ac					over, M ce's Fam		Tnc
ñ	Depar Impo any Ir		Shem Call	2-3-With	1 _							ett City		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Chh	ed the death. line. on(c (as a conseque)bstr	er the mode of	N .		or respiratory a			Approximatinterval Bet Onset and	tween
9	p ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseque	nice of).								
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	s that ned b		Part II. Other significant condition	ons contributing to death	but not result	ing in the u	nderlying cause	given in Pa	ırt 1.	23e. Did	tobacco ι	use contribute to	the cause of	death?
ğ	n requires been sign should be	ed b	Pulmonary	fibrosis						1 🔀	Yes 2	□ No 3□ P	robably 4 🗌	Unknown
Records,	The law recate has been page 2 sho	Completed by								24a. Was auto perfe 1 □ Yes	psy ormed?	prior to death?	utopsy findings completion of c	available cause of
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. PI	ace of Deat	h (Check only				
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'n	ing After une	ion:	27. Manner of Death 1 Natural 5 □ Pendin		njury Day, Year) 2	28b. Time of Injury		njury at Vork?		28d. Describe	how injur	ry occurred		
Division	eat he	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	ant ho	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	M eet, factory, offi	1 □Yes 2 ce	ŬN0	28f. Location ((Street an	nd Number or R	ural Route Nun	nber,
	Hospita 14 hours Funeral tely fille	Medical Ce		ng Physician: To the bes Examiner: On the basis and manner	of examination									s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie				29c. Lic	ense numb	er		29d. Da	te signed (Mont	h, Day, Year)	
			30. Name and address of person	Maryllum who completed cause of	F doath /ltow 1	22a) /Time	Print)	D003	635	3	May	te signed (Mont 4, 200	9	
			Sanda Mar	hallan R	altm	. I/1	Medic	d Ga	her 10	NI G	PLAG	St. Be	thomas !	W) 217
	Sta	te	31. Date filed (Month, Day, Year)	32. Kegis	strar's Signatu	1 1	arke		, , ,	141 01			- A PARTY CONTRACTOR	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 10 4 200 Ye as **Physician** 10419 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARKVILL BALTIMORY GENESIS SROMWEU CENTES. If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Director 153-28-5710 FEB 10. 1933 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expreiser must be notified at Director 1 □Yes 2√□No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Spring Time Way Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1957–60 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Mobile Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked off jury or other traumatic even Be Harry Simms Evelyn Petway ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Donna McLeod/wife 49 Spring Time Way Parkville, MD_21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 5/5/09 |Baltimore. MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ALRAY THAN CA Immediate Cause (Final CARDIAC **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner SCVO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dub to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 **1**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 □Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours a

To the Funeral L

State Registrar (Check only

29b. Signature and title of certifier

be do Mo

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8710 EMGE FEMILIAL PARK LICLE

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** :12AM James /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. vrs. last birthday. **Funeral** Hours Days JULY: **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Yes 2 □ No alten Funeral Director notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe ō ral", or items 23a or Examiner must be I -17-2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? ✓ Yes 22 No 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry ntal Hygiene. ed other than "nature event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Name/Relationship (Type. Print) S WIFE of Health a Lar 010 Department of Health Important: If item 27 any Injury or other tr once, 20a. Method of Disposition
1 ☐ Burial 2 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 4 Donation 5 Other (Specify) 21. Signature of Rungral Service Livense Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final **Physician** craon disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown FUNNOT Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 200 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dippatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer 5 Pending investigation 1 Yes 2 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 RES-000 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an 600 North Wolfe St, Baltimore, MD, 21287

Registrar

31. Date filed (Month, Day, Year) **MAY 0 5 2009**

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Emmett Robert F		1- For State Registrar			f Maryla	ind / [ment of ficate of	Health a Death	nd Men		Re	g. No.	20	09	1437
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		4a. Facility Name (mber)		14	b. City, Town,	or Location of		/lay 1, 200		inty of Dea		
		17127 Plea	sant Meac	low Ro	ad				Upperco				Baltir	more Co	ounty	
Funeral Director		5. Social Security N		6. Sex	л 2_F	7. Age (I	n yrs. last	birthday) 61 Yrs.	If Under 1 Ye Months Da		Min	. Date of Birt Jan。 1	,	1 0	Birthplace (St Country) [arylai	ate or Foreign
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after o	by F	3 Widowed	4 Div		Yes, Give Year		nown	1	Yes 2XX N	No specify:			Spe	cify: Wh	ite	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XX Burial 2 4 Donation 5	Cremation Other S	oecify:	Removal fro	om State	cre	matory or oth ganore	er place) e Cemete	ery	May 200	9	Unior	•		ryland
Salt Separt Mpor	1	21. Signature of Pu	ineral Service	Liconoe	,			22. N Eck	ame and Addre	ess of Facility Funera	11 Cha	pel, I	P.A.			07700
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cords, P.O. Box 6876 law requires that the death certificat has been signed by the attending ph 2.2 should be detached for use as the	by Pt	Part II. Other signi	ificant condi	ions o	ontributing to	death b	ut not resu	Iting in the u	nderlying caus	e given in Pa	art I.				to the cause	
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Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Completed											perfor		death'		2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ris after death. "I Director: After this certificate has been signed by tled in by the funeral director, page 2 should be detach	Be	25. Was case refer examiner?	red to medica		spital:					Other	-					
f Vi Physi er this	유	1 Yes 27. Manner of Dear	2 No		28a. Date	npatient		R/Outpatient Bb. Time of tr		njury at Work	Nursing H	d. Describe r	Residence		ner: Scene	
nding Pl th. :: After e funera	ë	1 Natural	5 Pen	dina	May 1, 2	Day Year	0	455 hrs	· · _	Yes 2	ين الا	bject in h				
ivisior or Attend after death Director:	Certification:	2 Accident	Inve	stigation	28e Place	e of Injury	/ - At home	e, farm, stree	et, factory, office		tc. 281	f. Location (S	Street and N	lumber or l	Rural Route	Number, City
Div ital or urs aft	er.	3 Suicide 4 Homicide		ld not be rmined	(Specify)						171	or Town, S 127 Pleasa	tate) nt Meadov	v Road, U	Jpperco, M	D
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 2		miner:0		of examin			red at the time, ion, in my opini							
F. 2 F. 8	Me	29b. Signature and	title of certific		ind mailiner Si	~			29c. Lice	nse number			29d. Date	signed (A	nonth, Day,Y	ear)
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OCME		30. Nam, and addr Melissa Bra			mple ed caus istant Med			,	enn Street,	Baltimore	e, MD 21	201				
	ate	31. Date filed (Mon	th, Day, Year)		32 Re	gistrar's	Signature	bar	end.							
Regist		M.	Y 05	2009	Den	m.	p.	101								
DHMH 17 Rev 1/20	101	***		4	-			ORIGINA	_							

09-03499	
Sandra Payne	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 14378

		- For State Registrar	Cer	tificate o	f Death	'n		Reg	. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)						Date of Death Month I	Day Year	3. Time of Death 0530 hrs
ledical Exami		Sandra Gay Payne						May 1, 2009		
		4a. Facility Name (if not institution, give stre 17127 Pleasant Meadow Road			4b. City, To Upper		ition of Death		4c. County of De Baltimore C	
			7. Age (In yrs. la	net hirthday)			Under 24Hrs.	8 Date of Birth		Birthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex		•	Months		Hours Min.	7	1 (Country)
Director			2XXF	45 Yr	s.			June 2	7, 1903 P	ennsylvania
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loca	tion					10d. Inside City Limits
ž .		·	1	TT -						1 Yes 2XXNo
daryland 28a-f show 1 at once.	흱	Maryland Baltimore 10e. Street and Number		Upperc	10f. Zip	Code		100	o. Citizen of What C nited Sta	ountry?
he Maryland 1 or 28a-f sho ified at once,	Director	17127 Pleasant Mead	ow Road			2115	5		nited Sta f America	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once			Was Decedent Ever in U.	s. I 13. W	as Decede			ecify Yes or No-		nerican Indian, Black,
eath v	Funeral		Armed Forces? Yes 2 XX No				xican, Puerto		White, etc	
fter d [", or		3 Widowed 4 Divorced If Yes	s, Give Year	1	Yes 2	X No sp	ecify:		Specify: Wh	nite
ours a	d by	15. Decedent's Education (Specify only high					Give kind of v		16b. Kind of Busines	ss/Industry
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			-	NOT use reti	ed)		
03(vithin ene.	Ē	12th		I.	Iomema				Own Hor	ne
15-C	_	17. Father's Name (First, Middle, Last)						(First, Middle, M		
	Be	Sterling Franklin 19a. Informant's Name/Relationship (Type,	Dei-4 \	10h Mailir	a Addross			ae Green	.WOOd_ oer, City or Town, St	rate Zin Code)
D 21 should and Mer 7 is man	욘			4.1	•	•				- 1
e, MD 21215-0036 1 and 2 should be filed within 72 hou Health and Mental Hygiene. item 27 is marked other than "nat rraumatic event, the Medical Exa		Mark Franklin (Brot		Place of Dispo					nsylvania 20c. Location - City	
Baltimore, permit. Pages I as Department of He important; If ite		1 XXBurial 2 Cremation 3 R	emovar nom State	crematory or o				ay 5,	The James Deed	
ti. Pa trant rtant y or o		4 Donation 5 Oher Specify: 1. Signification of Fruncial Service Licensee	Lir	nganore		etery Address of F		2009	outon Bri	dge, Maryland
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and M Important; If litem 27 is mainjury or other traumatic e		And WWALL		É	kharc	it Fun	eral C	hapel, P	·A.	yland 21102
Physician	-	23a. Fart I. Enter the disease, or complication	ons that caused the death	. Do not enter	the mode of	of dying, such	h as cardiac c	r respiratory arre	st, shock, or heart	Approximate Interval
Medical		failure. List only one cause on each lin	_{ne.} oke and Soot Inhala	ition						Between Onset and Death
xaminer		77.7	to (or as a consequence o							
		Sequentially list conditions, b								4
	i.	if any, leading to immediate Due to cause. Enter Underlying Cause	to (or as a consequence o	f):						
1	Examiner	events resulting in death) Last	to (or as a consequence o	f):						
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x 68° h certifi tending	ian	past 12 months?	Live birth Pregnant at time of de	anth =	etal death Other (Spe		Ectopic pregna	ancy	Month	Day Year
Box 687: death certifice the attending ped for use as the	Physician	1 Yes 2 No 9 V Unknown 9	Unknown	3 (Julei (Ope					
that the d ned by the detached		Part II. Other significant conditions con	tributing to death but not r	esulting in the	underlying	g cause giver	n in Part I.			e to the cause of death?
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eco ne law te has ge 2 s	ш							perform 1 ✔ Yes		h? Yes 2 No
Vital Recysician: The his certificate director, page	ပိ	25. Was case referred to medical	• • •				Death (Check			
Vita ysicia this ce direc	o Be	examiner? 1 ✓ Yes 2 No	tal: 1 Inpatient 2	ER/Outpatie	nt 3 C	OOA Oth	ier: 4 Nursi	ng Home 5	Residence 6 🗸 C	other: Scene
of ng Ph	Ë		28a. Date of Injury (Month, Day Year) May 1, 2009	28b. Time o	f Injury	28c. Injury a		28d. Describe h Subject in ho	ow injury occurred	
ion tendi eath. for: /	atio	1 Natural 5 Pending 2 Accident Investigation	May 1, 2009	0455 hrs		1 Yes	2 V No			
Division of Vital Records, tal or Attending Physician: The law requins after death. al Director: After this certificate has been so led in by the funeral director, page 2 should be	tific	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory	, office build	ling, etc.		treet and Number o ate) nt Meadow Road,	r Rural Route Number, City
Spital sours neral filled	Certification:	4 Homicide determined	(Specify) Farm/Ran					1		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examiner: On	To the best of my knowled	lge, death occ	urred at the	e time, date a	and place, and eath occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due t	stated. to the cause(s)
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	-	29b. Signature and title of certifier	11 80		29	O.C.M.			May 2, 2009	
		Men Granely	INS	- 00-1		J. J. 191.1				
OCM	E	30. Name and address of person who comp Melissa Brassell, MD Assis	olēted cause of death (Iten Itant Medical Exami		Penn St	treet, Balt	imore, MD	21201		
	tate	31. Date filed (Month, Day, Year)	Registrar's Signat			-,				
Regis		WAY 0 5 2009	Remar A.	Jav Jav	L.					

			1 - State Registrar			Cert	ificate of	Death		R	leg. No.				
			1. Decedent's Name (First, Middle,	Last)					2.	Date of Dear Month	th Day	Year	1	of Death	
	Physicia /Medic		BERTHA		K	PETE	250N			APRIL	29	2009	190	16 PT	VI
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	r Location of	Death		4c. C	County of Death			
ا مسر			JOHNS HEALINS B	AYVIEW INDOV	IAL CEN	TEX	Bn	CTIM	10:2E						
	Funeral		,		e (In yrs. last b	-	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birth (Month, Day IOV • 30	Year)	9. Birthp	lace (Sta try) • C •	te or Forei	gn
	Director		212 30 4605	1□ M 2□ F	32	Yrs.			Ι	100.30), <u>1</u>	926 N	· C ·		_
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loca	ation					1	0d. Inside	City Limi	ts
	/aryl	ō	MD		P.a	ltin	0000						1 □ Y	es 2□N	ю
	28a	Director	10e. Street and Number		Da	1 6 4.1	10f. Zip Code			1	10g. Citiz	en of What Cour			
1	3a or	<u></u>	4828 Claybur	v Ave.			2	1206			U	SA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	as Decedent of h	Hispanic Orig	in? (Specif	y Yes or No-	1-	4. Race - Americ		,	
0	or ite		1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	No		Yes, specify Cub	Specify:	ruerto nic	an, etc.)		Black, White,			
3	ral", c	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give ↑ Year or Dates:			□Yes 2□No	Зреспу.				Specify: bl	ack		
ה	72 h natu	Completed	15. Decedent's (Specify only highest	s Education t grade completed)	16	(Give k	ent's Usual Occup ind of work done	during most	of working	1	16b. Kin	d of Business/In	dustry		
7	han "	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5	i+)		O NOT use retire ousekee				Sta	te of	Mars	land	7
V	led w lygie her t		7th 17. Father's Name (First, Middle, L	nat)					e Nama /	First, Middle,			101		_
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Š	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, Inc Medical Examinar must be notified at	ဥ			10	h Mailine	Address (Street					Town State Zin	(Code)		
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ע	1 and 2 Health em 27 i		20a. Method of Disposition	ck (daugiii			ition (Name of atory or other pla		Date			ation - City or To			
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	permit. Pages Department of Important: If i any injury or once.		4 Donation 5 Dother (Sp. 21.28 nature of Funeral Service L	1 1	Jour	22	Name and Addre	ess of Facility	_	,2009		alto,M	a •		_
0	permit. Departr Importa any inju		Dolandino	7/1/5011	2.2.1	Ca	alvin B 112 E.	. Scr	uggs	Fune	ral	Home	1213		
H			23a. Part1. Enter the disease, or	complications that caused	the death. Do	o not ente	r the mode of dyi	ing, such as	cardiac or r	espiratory ar	rest,	, MO .	Approxi	nate	
	bycicion	6.3	shock, or heart failure. List of Immediate Cause (Final	only one cause on each li									Onset a	Between nd Death	
	hysician /Medical		disease or condition resulting in death)	a	a consequence	e of):						-	Vean	-1	
الممي	Examiner														
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):									
	ocuted nd ransi	Examiner	that initiated events	с											
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5	the d	Physician	1 □ Yes 2 🗷 No 9 □ Unknown	9 Unknown	it time of death	5	Other (specify) _								
Ľ	that t ed by detac		Part II. Other significant conditio	ns contributing to death b	ut not resulting	in the un	derlying cause gi	ven in Part I.		23e. Did to	bacco us	se contribute to f	he cause	of death?	
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	ne lav e has ge 2	m du								autop perfor	sy rmed?	prior to co death?	mpletion	of cause o)f
	iffical		25. Was case referred to medical					26 Place	of Dooth (1 □ Yes Check only o		1 □ Yes	2 MNo		
>	/sicia s cert lirect	o Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2.101 1 FR/0	Outnatient	3 □ DOA Ott	her				☐Other (Speci	fv)		
5	g Phy erthi eral c	ü	27. Manner of Death	28a. Date of Inju	ıry 28b	. Time of	28c. Inju			d. Describe h			97		
VISION	ath. F: Aft e fun	atio	1 Natural 5 Pending 2 Accident investig		iy, rear)	Injury		Yes 2□N	10						
2	Affe ecto by th	iji	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of (f)	ury - At home, c. (Specify)	farm, stre	et, factory, office		28	f. Location (S City or Tou		d Number or Rur	al Route I	Number,	
5	talor safte al Dir ed in	Certification: To	4 Enomoide	bunding, or	.о. (орослу)					0.1, 0. 70.1	,,, 0,,,,,,				
i	hospi houn uner ely fill		29a. Certifier 1 ✓ Certifying (Check only 2 ☐ Medical I	g Physician: To the best Examiner: On the basis	of my knowled	lge, death	occurred at the t	time, date an	d place, ar	d due to the	cause(s)	and manner as	stated. o the cau	se(s)	
	To the hospital or Attending Physician: he law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	and manner st	ated.		. ,	•							_
	5 with 50 00	2	29b. Signature and title of certifier	, A			29c. Licen	se number	014		29d. Date	e signea (Month)	∪ay, Yea	1)	
	ı		1 Olson	mall)			DOG	72868	7		UY	3016	07		
1	1		30. Name and address of person v	who completed cause of	death (Item 23a	a) (Type, F	29c. Licen DOD Print) SHOP	1 .	12	-	~ . ~	Madin	.//	2	
P	(V		31. Date filed (Month, Day, Year)	Dest Man	rar's Signature	uhn	s Hox	Ken	B	agui	cur	mence	21 66	me	1
	Sta Registr		31. Date mod (month, Day, 16al)	2000	J. Signature	1	a Red								
			MAY 0 5	2009 / Lens	un p	14									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** 12:10 PM MAY Robert Grey Rupert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGHES HOSPITAL Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Min. Days 1 X M 2 □ F Vrs Pennsylvania Director 72 Aug. 2, 1936 212-34-4795 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 X No Directo Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 23a United States 108 Forest St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 □Yes 2 🕅 No Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Northrop Grumman Technical Illustrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Harold Gray Rupert Mabel A. Lister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an Important: If item 27 is m any injury or other any once. Glen Burnie, MD 21061 <u> Mabel L. Rupert / Sister</u> 108 Forest St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition May 7, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Doylation 5 Other (Specify) 2009 Glen Burnie, Maryland Glen Haven Mem. Park 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, MD 21. Signature of Furieral 1110130 21061 Approximate Interval Between Onset and Death 23a. Part T Enter the dish se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HOURS PULMONARY HEMORRHAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 MNo 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Man or of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical

Records, P.O. Box 68760 pe Division of Vital Hospital or Attending e Funeral I

the Maryland

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier

P20656

29d. Date signed (Month, Day, Year) MAY 04, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE, BALTIMORE MD 21229

State Registrar KONSTANTIN ZUBELEVITSKIY 31. Date filed (Month, Day, Year) 0 5 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 April **Physician** 2:35 A. 30, Dorothy Zell Ray /Medical 4a. Facility Name (If not institution, give street and number) 1102 Prospect Mill Road 4b. City, Town, or Location of Death Bel Air 4c. County of Death Examiner Harford County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 6 Pay, 1937 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F 72 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic events once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 United States 1102 Prospect Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify:White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Southern States Petrolium Secretary 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Shepard Molly Zell Hess ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Prospect Mill Rd. Bel Air, MD 21015 John Ray / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 2009 Rel Air, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremat 3 Newport Drive Forest Hill, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cheonic obstructue pulmone /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami and the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☒No 24a. Was an has page 2 autopsy performed? certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled Medical 29a. Certifier fx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Dav. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

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615 W. Mar Phail

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Relair mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** April 6:13 P ^M Edna Lucille /Medical Reed 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford 32 N Hickory Avenue 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Yea 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs Director 85 13, 1924 Maryland 219-18-1736 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 TXYes 2 □ No Director Maryland Bel Air Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò items 23a 32 N. Hickory Avenue 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married ò 1 ☐Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Pages 1 and 2 should be Strawder (unk) Delp Mollie (unk) Hash မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 ls John Henry Reed / Husband 32 N. Hickory Avenue, Bel Air, Maryland, 21014 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important; If Ite
any injury or ot
once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Air Memorial Gdn. 5/4/2009 Bel Air, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ARTERIOSCUEROTIC CARDIOVASCULAR Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a.i.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has boom should be a secured. the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy funeral director, page 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sqrt{Residence} 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death.

neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR NORTH 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland

P.0.

Records,

of Vital

Division

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice Care

10b. County

15. Decedent's Education (Specify only highest grade completed)

RHODES

1XXM 2□ F

College (1-4or 5+)

LEONARD JOHN

5. Social Security Number

212-32-9311

10e. Street and Number

10a. State

Usual Residence of Decedent

Maryland | None

1 Never Married Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

John Rhodes

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

7. Age (In yrs. last birthday,

10d. Inside City Limits

XX Yes 2□No

Physician /Medical Examiner

Funeral

Director

28a-f show items 23a or 28a-f showner is ust by notified at Director Funeral permit. Pages 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: if them 27 Is marked other than "natural", or is any injury or other traumatic event, The Medical Exprinone. \$ Completed Be

Baltimore, Maryland 21215-0036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park □ Donation 5 □ Other (Specify) Signature of Funeral Service Lice see 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown O. 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed 24a. Was an 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of spital or Attending Phours after death.
neral Director: After ty filled in by the funer? 1 Natural 5 Pending investigation 1 Tyes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital of within 24 hours at To the Funeral D Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) = Bunc . Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

2. Date of Death 3. Time of Death 10:45P M

14. Race - American Indian,

May 3, 2009

4c. County of Death 4b. City, Town, or Location of Death Baltimore

Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 5,1935 9. Birthplace (State or Foreign Maryland

10c. City, Town or Location

Baltimore 10g. Citizen of What Country? 10f. Zip Code

USA 4000 North Charles Street #1208 21218

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes XXNo White Specify:

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Railroad Clerk

18. Mother's Name (First, Middle, Maiden Surname) Grace Sullivan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Verbraunia Elizabeth Rhodes Wife 4000 North Charles Street #1208 Balto MD 21218 20c. Location - City or Town, State

> May 6, 2009 Elkridge, Maryland 22. Name and Address of FaciMitchell-Wiedefeld Funeral Home Ind

6500 York Road Baltimore, Maryland 21212

Approximate Interval Between Onset and Death month

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 🗆 No

6 ☐ Other (Specify) 28d. Describe how injury occurred

N. Charles St. Belts. Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Dri 2009 num /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tospice Kandallstown timere If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) 1 M 2 □ F Months Days Hours Min. Country 218-46-976 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 Nisorehead Funeral 12. Was Decedent Ever in U.S. Arrest 1 Tyes 2 No. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 ₩o þ Specify 10 Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) aintenance 2 Health and Mental Hygidem 27 is marked other Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 000 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural oute Number, City or 🦙 n, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: if Item 27 any injury or other tr once. Noorehead Maxine au 110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 Removal from State 100 4 ☐ Donation 5 ☐ Other (Specify) f uneral Service Lice ee 21. Signatur 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** VAG Cana /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Saknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 | Yes 2 | → 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 406 po 6 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muli 26/29 D4768 MO

Registrar

State

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MA

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Man

5 NU

Registrar's Signatu

Swite

Milli

Maymora

31 Date filed (Month, Day, Year)

09-03325 Frank Swiston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 4385 State of Maryland / Department of Health and Mental Hygiene

December Name (First, Models, Last)		1- For State Registrar	Cer	rtificate of Dea	th	Re	g. N o.	
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100. City, Town or Location 100. City, Town or Location 100. City, Town or Location 100. City Codes 100. City C	Director	12.0	M 2 F	53 Yrs.	als Edys Hould II	12/30/	1955 <u> </u>	ountry) MD
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4 V Homicide determined (Specify) Townhouse / Rowhouse 2805 Erdman Avenue, Baltimore, MD 29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2805 Erdman Avenue, Baltimore, MD 29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2805 Erdman Avenue, Baltimore, MD 29a. Date signed (Month, Day, Year)	To the within To the comple					ed at the time, date :		
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 26, 2009	2	29b. Signature and title of certifier					l	onen, Day, Fear)
3 N me and address of person who completed cause of death (Item 23a)	3 V	Men Starsey	completed cause of death /Iter	m 23a)				
OCME Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	OCME				Street, Baltimore, M	1D 21201		
State 31. Date filed (Month, Day, Year) 32. kegistrar's Signature	State Registrar			8. ball	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per FH 9891 5/15/09 TT State of Maryland / Department of Health and Mental Hygiene Amend #22 per FH G891 5/18/09 TT Certificate of Death 1 - For State Registrar Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** mallwood 10:35 am 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner aris Towson
If Under 1 Year | If Under 24 Hrs. tospice altimore 9. Birthplace (State or Foreign Country)

Orth Caroline 5. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕶 F 215-66-Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director MU TIMORI 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2121 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 □ NO Specify ģ If Yes, Give Year or Dates: Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nonei **10**01 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be ပ smallwood 1anu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n Pages 1 and 2 imallwood Ave onald Son 3310 ake Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or others 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Trinity 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility March East 1101 E. North Ave. Baltimore MD 21202 Balto MO ह्येंड 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlyin, Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Vital 1 ∐Yes 2 X No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital r 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Nurse Practitionare estated. completely 29b. Signature and atle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, State MAY 05 Registrar

DHMH 17 Rev 1/2001

2009

SMALLWOOD

LORRAINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State_of Maryland / Department of Health and Mental Hygiene.

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	nend Item	"29d pe	Cer	tificate of	Death	2. Date of De		2009	3. Time of Death
Physicia /Medic Examin	al	Yvette Sikora 4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, or	Location of Deatl	Month 024	12	County of Death	9:50 AM
Funeral Director		218-42-6566	108P117 IM 21XF 7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D June 2	rth a <i>y, Year)</i>	altimore 9. Birt Co 23 Frai	hplace (State or Foreigr untry)
yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits
the Mai	recto	Maryland Baltimore	.1e			10g. Ci	itizen of What Co	1 ☐ Yes 2 🔽 No untry?			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, V w. N. Joal Evan, Inst. to not the continued at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		If	/as Decedent of H Yes, specify Cuba □Yes 2X\ No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh	
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2 shou and N is mai		19a. Informant's Name/Relationship (Ty	-		•	,	and Number or Ri			Zip Code)	
1 and Health em 27 ither tr		Claudette Sikora /	Daughter			Cordage		olumbia Date	<u> </u>	21044 ocation - City or	Town, State
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permit. Departm Importa any inju		21. Signarure of Funeral Servi License	ie	Crowns	22. K :		ss of Facility uddick Fu	neral I	Iome		21061
Physician /Medical Examiner											
ate be executed hysician and he burial-transit	ical Examiner										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Betopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month								23d. Date of de Month	livery Day Year
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		30. Name and address of erson who co		eath (Item 23a)		Chora	Lang	Cato	nsv	14 A	Nong
Sta Registr		31. Date filed (Month, Day, Year) NAY 0 5 2009	Registra	ar's Signature	par	Kal					`

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 6:45 AM 2009 NGRAM MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NA 2924 GRANTLEY AVENUE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 820-50-4768 1 X M 2 □ F 58 Director JULY 20,1950 MARYLAIUD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Funeral Director BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 2121 GRANTLEY AVENUE 2924 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: BLACK <u></u> 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within onent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NA 12TH GRADE DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TURNER PERCY SCROGGINS MARIONI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2924 GRANTLEY AVE, BALTIMORE, MD 21215 SCROGGINS (WIFE 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If its any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/11/2009 OWINGS MILLS, MARYLAND GARRISON FOREST CEM. 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Eacility SOSEPH M. BROWN JR. FUNERAL HOME JOSEPH 2140 1 N. FULTON AVE, BALTIMORE, MD 2121 ellean 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** counce disease or condition resulting in death) Ma /Medical Due to (or as a con a quence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical nding p as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for us 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o g Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law cate has I page 2 s autopsy performed? Yes 2 No 2 No certificate 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq \text{ Nursing Home} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To this After this funeral of 27. Mapper of Death
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Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation 1 Tes 2 🗌 No death. filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide

To the Hospital within 24 hours a

29b. Signatute and title of certifier

29a, Certifier

Medical

State Registrar

f death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

TIP-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOS7936

29d. Date signed (Month, Day, Year)

creenest Baitmore MO 21201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CERETHA 6:37 AM SAVAGE MA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-42-6995 1 □ M 2 🕶 F 68 Director MARYLAND DECEMBER 20,1940 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f show traumatic event, the "And cal Express trust be notified at 1 Yes 2 □ No Director BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? FULTON AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE SERVICES HEALTH AID GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEDRGE H. SAVAGE EVELYN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. CHARLETTE (DAUGHTER) 1558 N. FULTON AVE, BALTIMORE, MD 21217 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/04/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO 22. Name and Address of Facility SOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee Muamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final aspiration pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner subcorneal CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pul monay embolisms Due to (or as a consequence of): burial-transi physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ESRD SIP CRT 1998 on HD TITH, Sat 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cate has been a page 2 should PE on heparin drip, coumadin 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy perform HTN, DM After this certificate 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To eral Director: After thi filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Baltimore, Maryland 21215-0036

Box 68760,

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Vital Records,

Division of

death.

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P22077

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ECILY ML AGCADILI, 22 S. GREENE ST., BALTIMORE MD

31. Date filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	554		For 1 – State Registrar			Certificate of		F	Reg. No.	9 14390			
	Physici	an	1. Decedent's Name (First, Middle, Las Otto Carl St	<i>'</i>				2. Date of Dea Month MaV	3, 2009	3. Time of Death 5:15 A M			
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	CRAY	4c. County of De				
-			Ridgeway Mar				nsville		Baltin				
l.	Funeral Director		5. Social Security Number 6. S 214-14-9538 Usual Residence of Decedent	ex 7. Age (KD M 2□ F	In yrs. last birth	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 10	, 1909 M	irthplace (State or Foreign Country) aryland			
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	th with the 23a or 28	Funeral Directo	10e. Street and Number 18 North Beaumont	Avenue		10f. Zip Code 21	228		10g. Citizen of What C USA	Country?			
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Ë	2 should and Mer Is marke raumatic		19a. Informant's Name/Relationship (**	1				umber, City or Town, State, Zip Code) Winchester, VA 22603				
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			30. Name and address of person who	completed cause of deal	th (Item 23a) (7	ype, Print) Freder	de Ro	Cater	Julle, 1	b 2/228			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2005	32 Registrar's	Signature	bares							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 0.5 Year SEIDEL 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BAYVIEW MEDICAL BALTIMORE GNICK 8. Date of Birth (Month, Day, Year)
Tuly 2,1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min. 1 □ M 2 ☐ KF Months Days Hours 79 216-24-4405 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lîmits MD Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 607 Rockaway Beach Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Rodenizer Louise Truscott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Seidel /daughter 607 Rockaway Beach Avenue Balto. MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Cemetery 5/6/09 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY 3 Due to (or as a consequence of): DAYS HULMONAP" EDEMA Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) YEARS HYPERTENSION Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 XNo 1 ☐Yes 2 ☐No 1 ☐ Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

items

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Health and Mental Hygiene. em 27 Is marked other than "

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Pages 1 and 2 should

Baltimore, Maryland 21215-0036

executed burlal-tran attending physician the death certificate be the as nse be detached for the signed by The law requires that has been page 2 s this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

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Physician/Medical \$ Completed Be Certification: To

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

RES 001

MD

21224.

BALTIMORE

29d. Date signed (Month, Day, Year)

JOHNS HOPKINS

CENTER

BAYULEW MEDICAL

0

State

Medical

29b. Signature and title of certifier

DOCTOR

AVENUE

MEDICAL

EASTERN

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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au	d be ental ed o) Be	James Sipes				Mau	de Ma	adison		3. Time of Death 7:25a Country of Death Baltimore 9. Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1		
Maryland 21215-0036	mark	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stre	et and Numb	er or Rural	Route Number	City or Town	y or Town, State, Zip Code)		
<u>≅</u>	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, The Medical Evariation must be invitted at		Nancy Murphy/	Daughter	1127	Reams	Road	Midd	ile Ri	ver, N	1D 2	1220	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20058.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	place)	Da					
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B	Department Department Important in any ire		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Avenue Balt Connelly Funeral Home of Essex									21221	
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Division of Vital Records,	after Dire	Certification:	4 Homicide determined	building, etc		,,,			City or Tow	n, State)			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1. Certifying Pl	nysicien: To the best o	f my knowledge, dea	th occurred at the	e time, date a	and place, ar	nd due to the d	ause(s) and m	anner as	stated.	
	24 to Full letely	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examination and/or inted.	nvestigation, in m	y opinion, de	ath occurre					
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-	T		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)	UI TO	1			1		
	RA		Robert LiBerto.	Ms. 3,0	8 Bank	St Be	elto 1	me	2/2	77			
	St: Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		/			,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, 889 P. 05/28/09dh and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Day Year 2009 Willie H. Saylor May 1521 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year Months Days Hours Min 1**⊠** M 2□ F Director 08-31-1947 South Carolina 248 80 5284 61 Usual Residence of Decedent show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Widdow Evar, and rust be notified Director 1 □Yes 2 XNo MD Columbia Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6105 Turnabout Lane 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 1967–69 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Healthcare permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hopkin Saylor ပ Annie Mae Dash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan L. Boodoo Saylor/Wife 6105 Turnabout Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State injury or 4 □ Donation 5 □ Other (Specify) Ardent Crematory 5-14-2009 Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final ocaro Physician resume hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner therosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that the death certificate be executed pidemic burial-trar that initiated events resulting in death) Last Due to (or a consequence of) GOROVED aftending physician for use as the buria CERTIFICATI Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No. detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Nnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician; The inal certificate surgery 1 □Yes 2 NO director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

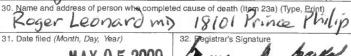
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

Division of Vital Records, P.O. Box 68760. To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:

> State Registrar

31. Date filed (Month, Day,

(Check only



29c. License number

1) 28791

Drive, Olney MD 20832

29d. Date signed (Month, Day, Year)

09-03088 Sar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ra Smith		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2009										1439	
Physicia dical Examin	n/	Decedent's Name (First, Midd Sara		2. Date of D Month April 17				Year		Time of Death 2329 hrs			
	ľ	4a. Facility Name (if not instituti Prince Georges Hosp		number)		4b. City, To		cation of D		4c.	County of C		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last I				If Under Months		If Under 24 Hours	Min		DD/YYYY) S	9. Birthpl Countr	ace (State or Foreign y) New York York City,
ě:	Ė	Usual Residence of Decedent			Yrs ty, Town or Local	1			July	11,1	704		d. Inside City Limits
nd how any	-1	10a. State 10b. County Maryland Char		Toc. Cit	Waldor:								Yes 2 No
ne Maryland or 28a-f show	0 I	10e. Street and Number 6030 New Fore	_	Apt. 4		10f. Zip C	ode 603				zen of What	_	
eath with the items 23a ust he noti	Funeral	11. Marital Status	12. Was De	ecedent Ever in l	U.S. 13. Wa				(Specify Yes or lerto Rican, etc.)	No-	14. Race - A White, e		Indian, Black,
s after de iral", or niner m	<u>a</u>	3 Widowed 4 Di	ivorced If Yes, Give Ye or Dates:	ear	1 _		No s		of work done		Specify:		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must he notified at once	Completed	Elementary/Secondary (0-12)	_	(1-4 or 5+)	during m	es Cle	g life. Do						rt Stores
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First, Middle					18.	Mother's N	lame (First, Middle	e, Maiden	Surname)		
2121 ild be fi Mental narked event,	2 Be	John Smi 19a. Informant's Name/Relation			19b Mailin	a Address	Street a	Sand1	ra Vero		Huds		n Code)
MD 2 shoulth and 1 is r		Kitt Kareem S		1)									and 20603
F E E E		20a. Method of Disposition 1 X Burial 2 Crematio		from State	o. Place of Dispos crematory or ot	her place)		M	Date 2,200)9	ocation - Ci	•	
Baltimo permit. Page Department of Important: injury or ott	1	Donation 5 Other S	Specify:	-110		Name and A	ldress of	Facility R	. N. Hor	ton C	ompan	у Мо	rticians,
	1	23a. Part I. Enter the disease, o	or complications that	caused the deat									n,D.C.2001
Physician /Medical Examiner	1	failure. List only one cause Immediate Cause (Final disease	e on each line. e a. <mark>Multiple In</mark>	juries			-,g,						Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as	a consequence	of):								
	튑	if any, leading to immediate cause. Enter Underlying Cause (Discess or in jury that imitiated events resulting in death). Last vents resulting in death). Last											
be ey be ey sician	Medical	UNPENDED IF FEMALE:	AMENDED	, outcome of pre	egnancy					230	l. Date of de	livery	
Box 6876 death certificate the attending phy of for use as the b	필	3b. Was decedent pregnant in t past 12 months?	the 1 Live	birth gnant at time of c	2 Fe	etal death		Ectopic pre	egnancy		Month	Day	Year
BOX	Physici	1 Yes 2 No 9 V Ur	Ja Oliki	nown					[22 pi	İ		4-4-41	cause of death?
s, P.O. irres that the signed by d be detach	음	Part II. Other significant condi	contributing	to death but not	resulting in the	underlying ca	iuse give	en in Part I.	_ 1 🗆 `	∕es 2 ✓	No 3	Probabl	y 4 Unknown
Division of Vital Records, P.O. Box 6876(Bospital or Attending Physician: The law requires that the death certificate 44 hours after death. Funeral Director: After this certificate has been signed by the attending phy liely filled in by the funeral director, page 2 should be detached for use as the b	Completed								pe	as an topsy rformed? s 2 No	prio dea		sy findings available pletion of cause of
tal Rec	ည္ခဲြ က်ိဳ	25. Was case referred to medical				26			eck only one)		-		
of Vital ng Physician: After this certi	의	1 ✓ Yes 2 No 27, Manner of Death	Hospital: 1	Inpatient 2 • e of Injury	✓ ER/Outpatient 28b. Time of		: Injury a		ursing Home 5	Reside		Other:	
tion c trending death. ctor: Aft	ation		nding Apr 17	th, Day Year) , 2009	2024 hrs			2 🗸 No	Pedestria				
Division sepital or Attendir hours after death. neral Director: A	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street 28f. Location (Street and Number or Rural Route Number, City or Town, State) Smallwood Drive near St. Patrick's Drive, Waldorf, MD											
To the Hos within 24 h To the Fun completely	<u>ख</u>	(0.10011 0111)	Physician: To the be aminer:On the basis and manner	s of examination		tion, in my o	oinion, de	eath occurr					ause(s)
	Ž	29b. Signature and title of certification (Card C. H.)	ier Allan				icense n D.C.M.				Date signed I 18, 200		Day, Year)
	t	30. Name and address of person Carol Allan, MD As	on who completed car ssistant Medica	,	om 23a) 111 Penn	Street, Ba	iltimore	e, MD 21	1201				
Sta Registr	-	31. Date filed (Month, Day, Year,	5 2000 32. F	Registrar's Signa	ature								
OHMH 17 Rev 1/200	_	**AI U	V-CUU3-1-/C	CALBERT	ORIGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year SCHREDER **Physician** BRANDON MICHAEL 22;30HM 2009 A POR /Medical Facility Name (If not institution, give street and number)
Howard County General Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2□F 40 **3, 1968** New Jersev Director 215-02-7463 May Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10h County 1 ☐ Yes 2 X No Catonsville MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 ral", or items 23a Examiner must b Funeral 6024 Chesworth Road United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 College Student n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Henry Schreder Karen Walz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau 6024 Chesworth Rd., Catonsville, MD 21228 Richard H. Schreder - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 □ Removal from State 5-3-2009 Glen Burnie, MD 5 Other (Specify) Atlantic Crematorv 22. Name and Address of Facility Ambrose Funeral Home, Inc. Stant the of Funeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Alcoholic 3-6 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4days Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events I or Attending Physician: The law requires that the death certificate be executed tracted.

Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burfail-transit Hepahic encephalopath 1-2 weeks resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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To the Hospital or within 24 hours a To the Funeral C

State

Registrar

VANCHA 31. Date filed (Month, Day, Year)

MAY 0 5 2009

Myltily

29b. Signature and title of certifier

Little Patrixent PKWy, PHUC. 10724 Redistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0064760

29d. Date signed (Month, Day, Year)

4130109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2009 Summers May 1 4:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2847 Spellman Road Baltimore 8. Date of Birth (Month, Day, Year) 8 - 2 5 - 1 9 3 9 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Min. 217-38-6966 Director 69 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 XYes 2 No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21225 2847 Spellman Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status be filed within 72 hours after ontal Hygiene. 1 ☐ Never Married 2 ☐ Married African 1 □Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 11th Grade land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holton permit. Pages 1 and 2 should by Department of Health and Minit Important: If Item 27 is mar/led any Injury or other traumatit er once. Morris Walter မ Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 2 1 4 19a. Informant's Name/Relationship (Type. Print) Deborah Jarvis Baltimore, Maryland 6213 Pioneer Drive 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD Crownsville VA Cem 05-08-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Doe to for as a consequence of Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2√No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Dea 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 24 hours after death. 2 Accident the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated.

10

Dec

Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

b.	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed

		State of Maryland / Depa			_	11,397
S. 898		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. 2. Date of Death	No.C U U J	3. Time of Death
Physicia		MARY JOSEPH STAAB			Day 2009 Year	6:05P M
/Medica		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Maria Health Care	Baltimore	(B: II	Baltimo	
Funeral Director		5. Social Security Number 217-05-2609 6. Sex 1 M XX F 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 0ct 30, 19	9. Birthj 219 Mary	place (State or Foreign ntry) land
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be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 6401 North Charles Street	10f. Zip Code 21212	10g.	Citizen of What Cou USA	ntry?
ns 23amust	era	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
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be file	Be	17. Father's Name (First, Middle, Last) George Staab	i	e (First, Middle, Mai et Wagner	den Surname)	
should and Mer marke matic	ှ		ng Address (Street and Number or Rui		itv or Town. State. Zi	p Code)
permit Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.		Sister Bernice Feilinger SSND 6401	North Charles Str			
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permit. Departr Importa any inji		Dounis Halle Runker	6500 York Road			
	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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g Phy gerthis	⊢ ⊦	27. Manner of Death 28a. Date of Injury 28b. Time of Manner of Death		28d. Describe how	e 6 Other (Speci injury occurred	ity)
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i or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date	e and place, and due	to the cause(s)
ro the vithin (or the comple	Mec	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	, Day, Year)
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1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1011	1 ~	100 212211
Stat	e.	and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Construction freeman (270) 31. Date filed (Month, Day, Year) NAY 0 5 2009 NAY 0 5 2009	iv. charles of	r. ONIT	more 101	M ABUT
Registra		MAY 0 5 2009 Serve B. Jan	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year 10:10 AM THOMAS SOSEPHINE 28,2009 APRIL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA 117 N. CAREY ST., APT. BALTIMORE 9. Birthplace (State or Foreign Country) N. CAROLINA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕱 F Months Days Hours 243-76-0132 AROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CAREY ST., APT. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: JZLACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMES GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BRAND JAMES CANADA SININIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STOCKTON ST., BALTIMORE, MD 21223 (30N) BOYD ROBERT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ZION CEMETERY 05/04/2009 LANSDOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 505EPH H, BROLDN JR. FUNERAL HEME SUHON, FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LEURAL EFFUSIONS Immediate Cause (Final MALIGNAN disease or condition resulting in death) Due to (or as a consequence of): AND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

burial-t physician at the burial. Box 68760 þe The law requires that the death certificate attending p for use as t Ö the signed by to σ. of Vital Records, cate has I page 2 s this certificate To the Hospital or Attending Physician:

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within 24 hours after death.

To the Funeral Director: /

Examiner Physician/Medical þ Completed Certification: To After thi funeral

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Physician

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traumatic event, the Medical Examiner must be notified at

/Medical

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3 Suicide

5 Pending investigation

6 ☐ Could not be

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determined

28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

20065861

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2717 HAMMONDS FERRY RD BALTIMORE, MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 55 1 AM Annold TIMM 2009 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore maryland medical University ac Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F 49 February 23, 1960 Maryland Director 218-76-8217 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show r items 23a or 28a-f shov item cust be notified at 1 ☐ Yes 2 INO **Funeral Director** Md. Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 8370 A Liberty Road 21701 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ∐Yes 2 TkNo Specify: White 7 is marked other than "natural", or traumatic event, the Madical Even. Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. 12 years 2 years Technician Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold Herman Timm Margaret Joan Powell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DE. 19970 31412 Oak Street, Ocean View, Mother Margaret J. 7 imm 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, Md. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) Signature of Funeral Service Licensee Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has but director, page 2 sl autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ResembleH MD AU417643541819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene taula Rosenblah 32 Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, perMD g891 5/5/09 IT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:30AM^M Addie Thompson 23,2009 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Golden Crest Nursing Center <u>Westminster</u> 8. Date of Birth (Month, Day, Year) 1/6/1916 9. Birthplace (State or Foreign Country)
S. Carolina 5. Social Security Number Age (In yrs. last birthday) Under 1 Year **Funeral** Days 1 ☐ M 2 🕱 F 93 Director 214-12-8975 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County r then "neturel", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 Types 2 □ No Director Carroll New Windsor Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3400 Hooper Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Crossguard Police Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Is marked of James Habersham Pages 1 and 2 should Addie Louise Drayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Importent: if item 27 Is eny Injury or other treu once. Lamont Thompson 6523 Lehnert St. Baltimore, Maryland. 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kings Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 4/29/09 Randallstowns.Md. 22. Name and Address of Facility
Estep Brothers FSPA.
1300 Eutaw Place, Baltimore, Md. 21217 21. Signature of Jineral Service Vicens 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SYEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Fu	neral Service	Licensee													e P.A.
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			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death	2. Date of Dea	th	3. Time of Death
П	Physici			DINGHAM		Month APRIL	Day Year	
- Marine	/Medic Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of De		4c. County of Death	
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	Funeral		1 □ M 2 □ F	. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		(, Year) Cou	nplace (State or Foreign untry)
	Director		219-28-7587 ^	81		Nov 27	, 1927 N	o_Carolina
	rylanc show	_	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	he Ma	Director	Maryland N/A		Baltimore		10-011	1 X Yes 2 No
	with t	l Dir	10e. Street and Number 2909 Joseph Avenue		10f. Zip Code 21225		I0g. Citizen of What Cou	•
	death	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer	ican Indian,
36	after or ite		Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give	¬N°	n res, specify Cuban, Mexican, Fu 1 □Yes 2 □No <i>Specify:</i>	erto nican, etc.)	Black, White Specify:	
215-0036	hours tural"	ed by	3 Widowed 4 Divorced Year or Date 15. Decedent's Education	es:	dent's Usual Occupation		16b. Kind of Business/I	Black
215	in 72 In "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give	kind of work done during most of w DO NOT use retired)	vorking		·
21	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "natural", or items 23a or 28a-f show aft, if the Modical Evarance must be notified at each than the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	Completed	12	01 0+)	Homemaker		Own I	Home
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Maryland 21	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene and the filed yield then 71 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Marical Experiment must be notified at	ပ	Sidney Garner 19a. Informant's Name/Relationship (Type. Print)	19h Mailir	ng Address (Street and Number or		atie Gee	in Code)
<u>8</u>	and 2 s eaith ar n 27 Is ner trau		Priscilla Burrell	111	909 Joseph Avenue Balt		-	<i>p</i> 3040)
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from SI	20b. Place of Dispo	sition (Name of matory or other place)	Date	20c. Location - City or T	own, State
	. Pages tment of tant: If it jury or o		4 Donation 5 Dother (Specify)	ale /	National Park Cemetery	05/02/09	Laurel, M	aryland
Ba	permit. Page Department of Important: If any Injury or once.		21. Signatur 11 Frif eral Service Licensee	11 101	2. Name and Address of Facility Feten Brothers Full	neral Service	РΔ	
			23a. Payt1. Enter the disease, or complications that car	ised the death. Do not ent	1300 Eutaw Place er the mode of dying, such as card	Baltimore, Md	21217 rest,	Approximate Interval Between
	Physician		snock, of heart failure. List only one cause on each	on line.	HAL HEMOR	000		Onset and Death
	/Medical			r as a consequence of):		ringe		
	Examiner	<u>.</u>	Sequentially list conditions, b.	HYPERT as a consequence of):	ENSION			1 day.
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	At BIAI	FIBRILLATION		-	
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9/9	certificate be executed ding physician and se as the burial-transit	lical	d					
×	ding se a	Physician/Mec	IF FEMALE: 23c If yes quiter	ome of pregnancy			201 Duty of 121	
XO RO	eath atter for u	ician	in the past 12 months?	th 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	Day Year
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<u>.</u>	w requires that the d	2	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to	
Hecords,	requi	eted						obably • Unknown
ĕ	he law e has b ige 2 st	Completed				24a. Was a autopsperformance	sy prior to o med? death?	topsy findings available ompletion of cause of
_	ding Physician: The law h. After this certificate has funeral director, page 2 &	O	25. Was case referred to medical		26. Place of D	1 ☐ Yes Death (Check only on	2 No 1 □Yes	No
	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital:	patient 2 ER/Outpatier			ence 6 Other (Spec	sify)
o u	Ing P	ü	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of (Month)		f 28c. Injury at Work?	28d. Describe he	ow injury occurred	· · · · · · · · · · · · · · · · · · ·
ISION	death death ctor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place 0	Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f Location (S	treet and Number or Ru	ral Route Number
2	al or A s after il Dire	Certification:	4 Homicide determined building	, etc. (Specify)	oo, natery, emoc	City or Tow	n, State)	arriodic rambor,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.		29a. Certifier (Check only) Certifying Physician: To the base Medical Examiner: On the base	is of examination and/or in	h occurred at the time, date and pla vestigation, in my opinion, death oc	ace, and due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)
	o the	Medical	one) and manne 29b. Signature and title of certifier	r stated.	29c. License number	2	29d. Date signed (Month	ı, Day, Year)
,	->=0		SOURABH VER	MA MIN	RES DI	00	APRIL,2	8,2009
1	1./		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)			
-	V		SOURABH VERMA 31. Date filed (Month, Day, Year) 32. Get	300 \	S HANOVE	R STREE	T, BA LTI	MORE
	Sta Registra		MAY 0 5 2009	wa B. A.	arts			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Please	• •	k Indelible Ink. Ensure A Department of Health and I	•	_	
		For State Registrar	State of Maryland / 1	Certificate of Death	Reg. N	0000	14403
Physici		1. Decedent's Name (First, Middle, I	Vonderho	ar	2. Date of Death	Day 2009	3. Time of Death 14:20 M
/Medio	er	4a. Facility Name (If not institution, g	Joshington St.	4b. City, Town, or Location of Death Houre de	SYCICE 8Date of Birth	Harf	olace (State or Foreign
Funeral Director		5. Social Security Number 318-72-6759 Usual Residence of Decedent	Sex 1 Age (In yrs. fast bit	Yrs. Months Days Hours Min.	NOV. 16 19	59 m	aryland
I and z should be fled within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. I maked other than "natural", or items 23a or 28a-f show wher traumatic event, I in Madical Evar. Evar. Ever Historical Health at the madical Evar.	ector	10a. State 10b. County	ford Hay	ure de Grace	10	Citizen of What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
leath with ti ns 23a or 2 irust ben	Funeral Director	10e. Street and Number 139 Nov Hour	Shington St. Ap	10f. Zip Code 2 1078 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	U.S.F.	gan Indian,
ours affer d ral", or iten	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	o Rican, etc.)	Specify: Wh	ite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. When 27 is marked other than "natural", or items 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, I'm Mardical Ever. Free is ust be redifficed an once.	Completed	15. Decedent's (Specify only highest (Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	Rind of Business/In	
e filed al Hygi I other vent, I	Be C	17. Father's Name (First, Middle, La	st)	18. Mother's Nam	ne (First, Middle, Maid	en Surname)	
ould by Mentanarked	To 1	John Vo	inderhaar	Mar	y Itam	ulton	
nd 2 sh llth and 27 is n r traun		19a. Informant's Name/Relationship	o (Type. Print) Friend 191	o. Mailing Address (Street and Number or Ri	Na Fores	y or lown, State, 21, + Hill n	nn 2 1050
of Hear of Hear it other		20a. Method of Disposition	20b. Place of cemete	of Disposition (Name of pry. crematory or other place)	Date 20c.	Location - City or To	own, State
t. Page tment tant: It		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		x1-DelAIA)-09 FC	prest H	111, mo
permil Depar Impor any In once.		21. Signature of Funeral Service Lic	censee Months	22. Name and Address et Facility	Fureral	Chapel.	BELANT
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,	1,100	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition resulting in death)	. \	priosclaratic Cardiava:	scular Disc	ase	Onset and Death
/Medical Examiner		resulting in death)	bue to (or as a consequence	of):			
- ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	of):			
e executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	of):			
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that the death certificate be ed by the attending physicie detached for use as the bu	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliv Month	ery Day Year
w requires that the de been signed by the a should be detached for	ed by Pl	Part II. Other significant conditions	s contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	
Hospital or Attending Physician: The law requires buss after death. Funeral Director: After this certificate has been sign tely filled in by the funeral director, page 2 should be	Completed				24a. Was an autopsy performed 1 □ Yes 2 🔏	prior to co	opsy findings available ompletion of cause of 21 No
s certifi	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Othors	ath <i>(Check only one)</i> Nome 5 X Residence	6 ∏Other (Speci	(f ₁)
th. : After this funeral c	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury 28b. (Month, Day, Year)	Time of Injury M 1 Yes 2 No	28d. Describe how in	· · · · · · · · · · · · · · · · · · ·	97
In other hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification: To	3 ☐ Suicide 6 ☐ Could not determine		arm, street, factory, office	28f. Location (Street City or Town, St		al Route Number,
e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my knowledg caminer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)
to the within 2 To the comple	Me	29b. Signature and title of certifier	MD Dezuty	29c. License number	29d.	Date signed (Month,	Day, Year)
		30. Name and address of person when the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco	no completed cause of death (Item 23a)	Type, Print) The Hill CT. Let	Lonville	Md >	1093
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				,
Registi		MAY 05	2009 Lenus S.	Barras			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30, 2009 **Physician** Katherine E. VanRossum 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MIddle River Baltimore Ivy Hall Nursing Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 13, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 2 🖺 F MD 214-14-9580 87 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Even inc. rout be notified at Baltimore Rosedale MD Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 USA 4 Pavia Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 🏻 No White þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Realty Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be find and Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Find Mental Fi Grace Waggner Earl Hewitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Pavia Court Baltimore MD 21237 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Douglas VanRossum /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/4/09 Dulaney Valley Baltimore MD 4 Donation 1/5 DOther (Specify) uneral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical a consequence of): **Examiner** sea se [arkinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 this certificate has been signed by the attending I al director, page 2 should be detached for use as Division of Vital Records, After death.

Maryland 21215-0036

Baltimore,

Be Completed

ours after death.

neral Director: A To the Hospital within 24 hours a To the Funeral C

Certification: To

Medical

State Registrar

5 ☐ Pending investigation

6 Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D0061907

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lhukwuma Ebo, 1124 Mace

28a. Date of Injury (Month, Day, Year)

Avenue, Butmore MD 21221

31. Date filed (Month, Day, Year) MAY 05 2009

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 Robert L. Valentine May 9:12 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Keswick Multicare Center Baltimore N/A 5. Social Security Number Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 219-42-0748 1**X** M 2□ F Months Hours 83 1, Director 1925 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director Maryland N/A Baltimore XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1117 W. 42nd Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♣DYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify. ≥ Specify. 3 ₩ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Departit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other teasures. 12 Foreman Lumber Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon Valentine Gertrude ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Etta Robinette Niece 1117 W. 42nd Street, Baltimore, Maryland 21211 . Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Glen Haven Memorial 5/6/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Fund ral Service Licensee 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1ean disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed? 24a. Was an has page 2 certificate 2 □ No 1 □Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide n 24 hours after de e Funeral Directo eletely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated within 2

State Registrar

Year

and address of person who completed cause of death (flem 234) (Type,

29b. Signature and title of certifier

Date filed (Month, Day,

30. Nam

Registrar's Signature ORIGINAL

(4)

Print)

Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:00 PM 2009 /Medical 4c. County of Death 4a. Facility Name (If not inetitution, give street and number) 4b. City. Town, or Location of Death **Examiner** 326 Anne Hanover 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 F -26-0038 August 20 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exp., incr. must by multified at Director 1 Yes 2 No Hone rumo Hanover 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21076 7326 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 [] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BO þ If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Kimbrough 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DIMMS ပ Diron lare 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trau Pages 1 and 2 Dorothea Ten Burun Hebron-Nier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J F Ineral Service Livensee 22. Name and Address 10220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ icate has been siç ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \(\sum \) Nursing Home 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No investigation 1 Tyes 2 Accident To the Hospital or Attende within 24 hours after death To the Funeral Director; the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 3/322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN CHOICE (1) 121DEEP ND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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		For State Registrar	State of M	laryland / Do	epartmen C <i>ertificat</i>			and Menta	al Hygier Reg. N	2009	14407
Physicia	n	1. Decedent's Name (First, Middle	· ·	**					te of Death	Day Year	3. Time of Death
/Medic	al	Lillian France 4a. Facility Name (If not institution,		1	4h City	Taura as	Location o	May		2009 Year	8:15P. M
Examine	er .	123 Theodora Co	-	,	•		t Hil	1		Harford	
Funeral		5. Social Security Number	6. Sex 7. A 1 □ M 2 X F	ge (In yrs. last birth	day) If Under		If Under 2	24 Hrs. 8. Da Min. (M	te of Birth onth. Day. Yea	9. Birt	hplace (State or Foreign untry) sachusetts
Director	-	022-22-8145 Usual Residence of Decedent	TOW ZAF	79 Y	rs.			Feb	. 14, 1	1930 Mass	sachusetts
yland how at		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
ne Mar 8a-f s	Sco	Maryland Hari	ord	Fores	t Hill						1 □ Yes 🏞 No
with the	Funeral Director	10e. Street and Number			10f. Zip					Citizen of What Co	ŕ
death ms 23	Jera	123 Theodora (12. Was Decedent	Ever in U.S.		050 lent of Hi	spanic Orio	gin? (Specify Ye		ted State	
030 urs a	2	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	>	If Yes, spec	ify Cuba	n, Mexican Specify:	, Puerto Rican,	etc.)	Black, White Specify: Whi	e, etc.
15-00%	lete	15. Decedent's (Specify only highest	Education grade completed)	1 (ecedent's Usua Give kind of wor ife. DO NOT us	rk done d	urina most	of working	16b.	Kind of Business/	Industry
212 I withii giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	emaker	se reurea,	,		0	n Home	
nd he filed al Hyg	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother	r's Name (First,	Middle, Maide	en Surname)	
yla; ould b i Ment narkec	2	John Hurley					Lill	ian All	en		
Maryland d 2 should be file tith and Mental Hy ti is marked othe traumatic event		19a. Informant's Name/Relationsh		1						or Town, State, 2	
re, land the Heal	3	John E. White /	Husband	20b. Place of D	3 Theodo	ne of				Marylar Location - City or	
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, Its Medical once.	Ì	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service)	ecify)		d Mem. (Gard	ens	May 6, 2009	Ald	lino, Mar	yland
Bal permi Depa Impor any Ir) four lek	aug		Evans I 3 Newpo	Tune ort I	ral C Drive	hapel & Forest	Cremat Hill,	ion Serv Maryland	rice-BelAir 1 21050
Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	-a Hepa	d the death. Do no ne. + OC U/U a consequence of)				cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
executed executed ial-transit	EX	Sequentially list conditions, if any load in cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of)							
	dicai	•	d								•
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ds, P	5	Part II. Other significant condition	s contributing to death b	out not resulting in th	ne underlying ca	use give	n in Part I.	23	e. Did tobacco	use contribute to	the cause of death?
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Pec e law r has be	adu .	Hyperten	sion '					24	a. Was an autopsy	prior to c	topsy findings available completion of cause of
Vital Rician: The Certificate hat ector, page		Hyperlips	demja					1.0	performed? Yes 2 □ N	death?	
Vita		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ☐ ER/Outpa	ations 2 DO	Othe		of Death (Chec		- 50	
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To the Hospital o within 24 hours aft To the Funeral Di completely filled it	בחוכשו	(Check only 2 Medical E: one)	Physician: To the best caminer: On the basis of and manner st	f examination and/	or investigation,	in my op	inion, deat	d place, and du h occurred at th	e to the cause(le time, date al	(s) and manner as nd place, and due	stated. to the cause(s)
To to To Com	2	29b. Signature and title of certifier **Mobiled 1.	of was			License		- Marja		ate signed (Month) 5 / 0 4 /	
	3	0. Name and address of person w	no completed cause of co	leath (Item 23a) (Ty	pe, Print) e Rogd	Su	ite	102 B	21 A)	r. Marri	2009 1404 21015
State		1. Date filed (Month, Day, Year)	32. Region	ar's Signature	-1-	0		. ,		1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 Day 12:18PM Catherine C. Winder May 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 12/15/1916 7. Age (In yrs, last birthday) Hours 1 □ M 212 F 216-01-2848 92 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Nottingham 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Cardwell Avenue #210 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 □Yes 2XNo Specify: White Specify 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Westing House College (1-4or 5+) Assembler Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Clark Margaret Wasserman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Wilkens/Niece 8417 Maryland Road, Pasedena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery 05/06/09 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD 4 □ Ponation 5 □ Other (Specify) 21. Sign ture of Funeral Service License Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final is ase or condition resulting in death) Asportion Numma the to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 X No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🖔 To the Hospital

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31. Date filled (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

erson who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Kury Sw Gly Byrne MD2/06/

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Physicia Medical Exami		1. Decedent's Name (First, Midd John M. Wa	lters, Jr.					2. Date of Dea Month April 29, 2	Day Year 2009	3. Time of Death 0734 hrs
		4a. Facility Name (if not instituti Johns Hopkins Hospi			41	Baltimore	or Location of	Death	4c. County of D	
Funeral Director		5. Social Security Number 225–12–1969	6. Sex 7. Ag	e (In yrs. last b	irthday) Yrs.	If Under 1 Ye Months Da	ear If Under tys Hours	Min.		. Birthplace (State or Foreign Country) orth Carolina
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ith the Maryland 23a or 28a-f sho notified at once	Dire	10e. Street and Number 1247 Roundtop	Road			10f. Zip Code			USA	Country?
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5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	ompleted	15. Decedent's Education (Spe Elementary/Secondary (0-12)		5+)	during mos	s Usual Occup et of working lif tendent	fe. DO NOT u	nd of work done se retired)	16b. Kind of Busine	,
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle John M. Walter	S				18.Mother's	Name (First, Middle,	an	
and 2 should be fealth and Mental tem 27 is market traumatic event,	-1	James R. Walte 20a. Method of Disposition		9	745 Bt		Rd Jac	per or Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Num	mber, City or Town, S	5
MOFE Pages 1 ent of Fi		1 Burial 2 Crematio 4 Donation 5 Other S 21 Signature of Funeral Service	licensee C m. 11	Metro	Crema	atory,	Inc. 5	5/1/09	20c. Location - Cit	re. MD
		23a. Part I. Enter the disease, o	Todd	Dring	z99	ation Freder	Societ ick Rd	y of Mary Laltimore	land, Inc.	8
Physician /Medical examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ot Wound of		mode of dying	g, such as car	rdiac or respiratory ari	est, shock, or heart	Approximate Interval Between Onset and Death
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	sician	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Un	I LIVE DILLII	ne of pregnancy	2 Feta	I death 3 er (Specify)	Ectopic p	pregnancy	23d. Date of del Month	ivery Day Year
P.O.	2	Part II. Other significant condi	tions contributing to death	but not resulti	ng in the un	derlying cause	given in Part		s 2 No 3	e to the cause of death? Probably 4 Unknown
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Division Division Hospital or Attendi 24 hours after death. Funeral Director: /	Certification:	3 Suicide 6 Cou	ld not be 28e. Place of Injurined (Specify) Single			factory, office	building, etc.	or Town, S		r Rural Route Number, City , MD
To the 110 within 24 F	평		hysician: To the best of my iminer:On the basis of exam and manner stated.							
.		29b. Signature and title of certific	er				se number		29d. Date signed April 30, 2009	
60	1		sistant Medical Exam	,		eet, Baltim	ore, MD 2	21201		
Sta Regist		31. Date filed (Month, Day, Year)	32. Fegistrar	's Signature	bas	1				
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State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 4:45 P M Anne Marie Wollenweber 2009 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec 12; 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1932 Mary Land 1 □ M 2 🕅 F 76 220-28-2486 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Dedical Extraction of the profiled the contractions of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction 1 □Yes 🎖 🗆 No Director Perry Hall Maryland Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21128 **USA** 2A Brook Farm Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iter any Injury or other traumatic event, Ite Medical Exercit al. once. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Rathall Norman Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2A Brook Farm Court Perry Hall, Maryland 21128 Norman Wollenweber, Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/02/09 Baltimore, Maryland 21. Signature by Funeral Service Lice Thomas Gregor Tremarionss Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4EARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month 5 Other (specify) ☐Yes 2 No ed by the detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2.No 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 □Yes 2 □ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 hou To the Fune completely fi the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, BUITE 209 BALTIMOREIMA 21204 MD DANIEUE DOBERMAN 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 1/2001

8. Date of Birth (Month, Day, Year) July 9, 1917 Birthplace (State or Foreign Country) Tennessee 10d. Inside City Limits 1 □Yes 2√□No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: American Indian 16b. Kind of Business/Industry Factory 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 76 Smith Road Gardners, PA 17324 20c. Location - City or Town, State Baltimore, Maryland ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 □No 1 ☐Yes Other: 4 Nursing Home 5 Residence 6 Other (Spe Certification: To 28d. Describe how injury occurred 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only 29c. License number DØØ 16 387 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 1716 HARFOUR ROOD SUITE 105 PALLSTON MD 21047 DERFECTO C. VALARAO, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3 Time of Death

рм

6:30

 200^{Year}

Harford

4c. County of Death

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20h - corper FH 889 1 5 / 21 / 09 TT Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year PM **Physician** 30 2009 04 ndrew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland Medical Center Baltimore 5. Social Security Number Birthplace (State or Foreign Country) Year If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Min 4-6-1960 363-76-7848 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. In Department of Health and Mental Hygiens in Tatural", or items 23a or 28a-f show Important: If fem 75 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be a wiffind at 1 ☐ Yes 2 ☐ No Director Catconsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 1013 Marksworth Road by Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Correctional officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julie Mae Ford Henry Lee Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1013 Marksworth Road, Catonsville, MD 21228 Yolanda Yvette Watts/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Custer Nat 1 Cem 5/12/2009 20c. Location - City or Town, State 20a. Method of Disposition Augusta, MI Crowsville, M 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. re of Funeral Service Licenses 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I year Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a c quence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 □Yes 2 □No n 24 hours after death.

Re Funeral Director; A

Jetely filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 052477 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9.00v 0 31. Date filed (Month, Day, Year) NAY 0 5 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:30 P 29 APRIL BOWEN PATTISON WEISHEIT SR. 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HAVRE DE GRACE HARFORD HARFORD MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 X M 2 □ F 21, 1918 Maryland Director 90 Aug. 219-10-2374 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant; if Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | <u> Harford</u> Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2636 Calvary Road 21015 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) <u>Law Practice</u> Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ingreet (nmn) Bowen Joseph Elmer Weisheit Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> 2636 Calvary Road, Bel Air, Maryland 21015</u> <u>/ Wife</u> B. Weisheit permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date f Disposition 2 Crema oval from State 5 □Oth Hilltop Service Corp. 5-4-09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, ns that caused the deock, or heart failure. ate Cause (Final **Physician** aden Cardiac dise or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç , page 2 should b Completed Bower 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
May 1, 2009 29b. Signature and title of certifier 29c. License number D0057223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 pper chosepealer Drive Bel Air, MD 21014 Barrueto mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Thomas Wandishin **Physician** 30 2009 12:54 p April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner **Baltimore** Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F PA 86 Director 8 Nov. 1922 184-12-8323 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at Director 1 ☐ Yes 2 XNo Timonium Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 2300 Dulaney Valley Rd. C102 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No
If Yes, Give Year or Dates: 43-146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 📉 No Specify: ģ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Julia Hama Michael Wandishin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. 2300 Dulaney Valley Rd., Timonium, MD 21093 Irene Wandishin/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/1/09 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Michael 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown has been signed be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 X No s certificate ha 1 ☐Yes 2 ☐No **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death, neral Director; / filled in by the f 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) oneX Nurse Practitionerner stated within 2 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and fittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JACKIE JONES, CRNP

31. Date filed (Month, Day, Year)

2009

30,

APRIL

THOMAS WANDISHIN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Box 68760.

P.O.

Division of Vital Records.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** SAAC OUNG 2:10 AM APRIL 29,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SANDTOWN If Under 24 Hrs. 8. FUTURECARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 69 10XM 2□ F 214-38-4583 Yrs DECEMBER 24, 1959 S. CAROLINA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No Director MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ CATHERINE U.S. A. 200 or Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "no eny injury or other traumatic event, the Market once. Elementary/Secondary (0-12) College (1-4or 5+) FINISHER CAPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) YOUNG SOE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005. CATHERINE ST., BALTIMORE, MD 21223 MANICY YOUNG (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT. CARMEL CEMETERY 03/04/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

SEPH H. BROWN JR. FUNERAL 21. Signature of Funeral Service Licenses 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancel /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dlev Accident certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy ŏ Year Day 5 Other (specify) 4 Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Hospitel or Attend 24 hours after death Funeral Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number allelles 30. Name and address of person who completed cause of d. ath (IIv m 23a) (Type, Print) 413 common neath AU catast

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State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200 9 3, May 1:27 PM Richard A. Youngquist 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Halethorpe 3010 Virginia Ave If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 214-54-7559 25, 1950 58 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21227 3010 Virginia Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No 3 ☐ Widowed 4 🏋 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Waste Disposal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Youngquist Mary Ditty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 268 Michele Ave Millersville, MD 21108 Michael Youngquist/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc 5/4/09 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. tho 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCINOMA SMACL Due to (or as a consequence of): METASTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2. No 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of Injury

/Medical **Examiner** certificate be executed and the burial-trar attending physician

Division of Vital Records, P.O. Box 68760,

Physician

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed

Be

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Certification:

Medical

Funeral

Director

"natural", or items 23a or 28a-f show

injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic according to the permitted of the permitted of the permitted or other traumatic according to the permitted of the permitted or other traumatic according to the permitted of the permitted or the permitted of the permitted or the permitted or the permitted of the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitted or the permitte

death with the Maryland

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Yes 2 ☐ No . Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier (Check only

27. Manner of Death

J ∐ Natural

2 Accident

4 ☐ Homicide

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number 385 95 29d. Date, signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE, 2835 ASNEEM

State Registrar

To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director, After this certifica

completely filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Rene C. Alvarez 2009 18. Apri1 12:11 A. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months Days Hours 131 20 4606 81 March 21. 1928 New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No XX Maryland Prince George's Capital Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5003 Doppler Street 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Postal Carrier US Post Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benito J. Alvarez Ida C. Hauser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Alvarez (WIFE) 5003 Doppler Street, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 23, 2009 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 old 21. Signature of Funeral 70015 Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ardisa week Due to (or as a consequence of) schem Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contrib<u>ut</u>ing to death but not resulting in the underlying cause given in Part I. 2FTNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 XXIo cripheral 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "any injury or other traumatic event, the Mesonee.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

2 Accident

4 Homicide

(Check only

John

29b. Signature and

3 Suicide

29a. Certifier

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be multipled at

filed within 72 hours after

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans physician s the burial attending pl for use as t ed by the detached i page 2 s has

Box 68760,

P.O.

Records,

Division of Vital

certificate director, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

6 ☐ Could not be

title of certifier

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Branch

20/2009

re, Suite 203 D, Clinton, m)

State

Registrar

To the within 2

31. Date filed (Month, Day,

700 32, Registrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a, perPHYS, #22perFH, G891,575709, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** CAROLE BROWN April 0030 2009 12 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WHIGHE Western Maryland Health System Cumber and Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan Allegan All Allegany 9-Birthplack (State or Foreign Memorial Campus 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F 84 Yrs Director 234-38-8084 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Show ed other than "natural", or items 23a or 28a-f show event, the Medical Evantines must be notified at 1 XYes 2 □ No Director WV Paw Paw Morgan the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t USA 25434 126 Magnolia Road by Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Heatth and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗙 No Specify: Specify: White 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sara Elsie Oliver Wilson L. Moreland ဂ္ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Magnolia Road Paw Paw, WV Austin Brown - Son Pages 1 a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Camp Hill Cemetery April 14,2009 Paw Paw, WV 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Avenue Kimble Funeral Home
188 Mosser Avenue Paw Paw WV 25 Paw Paw, WV 25434 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** ASRIRATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for sela consequence of: burial-trans the attending physician and thed for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 XNo ္ရ 1 patient 2 ER/Outpatient 3 DOA this funerai 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification; 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No death hin 24 hours after deat the Funeral Director: in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0025406 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

WILLIAM LAMM, M.D.

31. Date filed (Month, Day,

MAY U 5 2009

32. Registrar's Signature

900 SETON DR. COMBERIAND, MD

2502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PM Nora M. Bosak ,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Oct. 31, 1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** A labama 417-40-9621 75 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Modical Expansion to the confined at once. 1XXYes 2 ☐ No Prince George's Greenbelt Mərylənd Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 18 Lakeside Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🔀 No Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Computer Programmer Municipalities 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Philip O'Brien Mullane Joy Dovel ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2319 Jupiter Court Bartlesville, OK 74006 Diana G. Hiatt - Stepdaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4/17/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Bonard Moder Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1400 Physician aid disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Physician/Medical Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 BNo 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 💆 No 1 □Yes 2 X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2N ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, n 24 hours after death.
e Funeral Director: Aft To the Hosp within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

Medical one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD61131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8100 Good Luck Rd., Lanham, MD 20706 31. Date filed (Month, Day, Year) 32 Registrar's Signature 21

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Registrar

20

29a. Certifier

(Check only

			For State Registrar	1 104		of Maryla	nd / Dep		t of H	ealth a		•		2000		421
			1. Decedent's Nar	ne (First, Middl	e, Last)							2. Date of D	eath		3. Time o	of Death
	Physici		Car1	Truman		Bell						Month April	16,	2009	9:30	РМ
-	/Medio Examin				n, give street and no			4b. City,	Town, or	Location of		1 -		County of Dea	th	
			Manor	Care				Ch	evy	Chase	2		I	Montgom	ery	
	Funeral		5. Social Security	Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth	9. Bir	thplace (State	or Foreign
	Director		329-32-8		1 X M 2 □ F	69	Yrs.	Months	Dayo	110010		larch		940 I11		
	pua w		Usual Residence of	10b. County		100.0	City, Town or Lo	ocation							10d. Inside C	City Limits
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	the M	ect	10e. Street and Nu	none				10f. Zip		- 100			10a Citi	zen of What Co		
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(0	fter d riten	F.		ried 2 K Marr	Armed F	orces?	63	If Yes, spec	ify Cubai	n, Mexicar	n, Puerto F	cify Yes or N Rican, etc.)		Black, Whit		
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0-0	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, Ite Medical Examinar must be notified at	ted	/0	15. Deceden	t's Education		16a. Dece	dent's Usua	ol Occupa	ation	A a d complete		16b. Ki	nd of Business	/Industry	
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7	ed wil ygien er th	S			4		Eco	onomis					1	bal Fir	ance	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Marical Experiment must be natified at once.		19a. Informant's N	lame/Relations					,					r Town, State,	•	
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	ospi hour uner uner	cal	29a. Certifier (Check only	1X Certifyin	g Physician: To the Examiner: On the l	e best of my kr	nowledge, deat	h occurred	at the tim	ne, date ar	nd place, a	and due to th	e cause(s) and manner a	is stated.	(e)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month April 18, 1425 Lawrence James Beasley, Jr. 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Stella Maris Nursing Home Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 12, 1941 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 6. Sex Months Days Hours Min. 1**XX**M 2□ F 557-54-4200 67 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Howard Columbia 1 ☐ Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21044 10328 Hickory Ridge Road, #611 12. Was Decedent Ever in U.S. Armed Forces? 1. ★ es 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1958–1962 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 N Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advisor Insurance Company 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glavdus M. Brown Lawrence James Beasley, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4376 Broadway Street, Lake Worth, FL 33461 19a. Informant's Name/Relationship (Type. Print) Lanee Safai / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date April 20, 2009 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligense Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 Trekard L. Halen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic Adenocarcinoma 1 month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2XXNo 1 ☐ Yes 2 XNo 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

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Division Hospital or Attending Department of Health Important: If item 27 any injury or other treater.

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Pages 1

Baltimore, Maryland 21215-0036

Examine burial-trar attending physician for use as the buria Physician/Medical signed by the a detached <u>6</u> Completed page 2 s funeral director, Be <u>6</u>

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown

Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5XX Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1**√X**Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

April 20, 2009

**Certifying Physician: To the best of my knowledge/ death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

29c. License number 29d. Date signed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print)

30. Name and address of person wa Marc R. Shepard

State Registrar Year,



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registral FIDE TO MEA - 30-09, HW, Mc Gertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2:00a M April 2009 Bland 18. Juanita /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 12900 Marcia Rd. Ft. Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 ☐ M 2 🕱 F Yrs. Jan 7, 1930 Washington, DC 79 Director 577-44-3157 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evertingt must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director Clinton Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20735 5312 Plata St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 24 No Specify: Specify. ģ 3 ☐ Widowed 4 🖾 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Department International Specialist 2yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Harry J. Chase Wilma Thomas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clinton, ,D 20735 5312 Plata St. Paula Bland - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-24-2009 Suitland, MD. 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 22. Name and Address of Facility Murray Funeral Home 21. Signature of Funeral Service Licensee 4804 Georgia Ave. NW Washington, DC 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition End Character Renal Disease Physician End disease or condition resulting in death) /Medical Due to (or as a consequence of):

Hypertension
Chronie Airway Ob Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed CERTIFICATION AP Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 TNo P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Arter this certificate has been sign-funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown End Stage Renal Disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease autopsy performed 2 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?
11 Yes 25 No. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

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ral", or Items 23a or Examiner must be r

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filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

physiclan and s the burial-transit use as this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

29c. License number

46046

11711 Livingston Road, Fort Washington, MD 20744

29d. Date signed (Month, Day, Year)

Medical

Hospital

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

APR 2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza-Alikhani, MD

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 18, 2009^{Year} **Physician** Joyce Ann Bressi 3:20 A M /Medical 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 3223 Throne Drive Calvert Dunkirk 8. Date of Birth (Month, Day, Jan 8, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 212 F 66 165-32-9439 1943 Pennsylvania **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Exemiter mast be notified at MD 1 ☐ Yes 2 ☑ No Director Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3223 Throne Drive 20754 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, Ite Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Jurewicz Verna. 2 Promec 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3223 Throne Drive Dunkirk, MD Albert Bressi (husband) 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dat 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory April 20 4 □ Donation 5 □ Other (Specify) Clinton, MD 21. Signature of Funcial Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 2Gary 3. Goif 8125 Southern Maryland Blvd. Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se 212 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): re Epiglottis Cance Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes → No Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □ Yes 2 1 N 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Ser Residence 6 Other (Specify) 1∐Yes ⊅ZNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ath (Item 23a) (Type, Print) 30. Name and address of person who completed cau

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State Registrar owenthal

31. Date filed (Month, Day, Year)

32. Registrare Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12 2009 2:15 A M April Doris Ruth Brady /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Eldercare Hammonds Lane Brooklyn Park Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Days Year 1 □ M 2 🖫 F Months Ĩ920 88 Director 220-05-3130 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2¥ No **Funeral Director** Anne Arundel Pasadena MD the 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 mijury or other traumatic event, the Medical Examiner must hermone. USA 21122 206 Golden Crown Way Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No W 14. Race - American Indian, Black, White, etc. 1 →Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WWII 1 ☐ Yes 2 ☐ No Specify. 2 Specify: 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Hutchinson William H. Grimes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 Golden Crown Way, Pasadena, MD 21122 Tom Wingate - Grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet Cem | 4/17/2009 Crownsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses John M Taylor Funeral Home, Inc. Mexim T. Blober 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MOUMONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obstructive Lung DIS-Per hronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are the cause) Due to (or as a consequence of): Examine attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Year Month signed by the at d be detached fo 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has li rector, page 2 s autopsy 2-No 2X No 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. after death

Director: , within 24 hours aft

To the Funeral Di

completely filled in

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (-HMbalaVaNaV. 7845 Oakwood Road

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 2 0 2009 32. Registrar's Signature

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at

Funeral Director

/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

		For State Registrar 1. Decedent's Name (First, Mid	dle la				Certifica	ate of	Death	-		Reg. N	Dram July	0 7	3. Time of I	Death
nysicia		Jerome Willia		Bass									^{ay} 200	9 Year		5 P ^M
/Medic xamin		4a. Facility Name (If not institute 18889 Waring	ion, giv					ny, Town, o	r Location of Death					y of Death		
ineral rector		5. Social Security Number 579–52–1459	6. S	ex MM 2□F	7. Age (In yrs.		/rs. If Unc	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. I	Date of Birt Month, Da Or . 3	h y, Ye <i>ai</i>	940	9. Birthp Cour Wash	place (State or ntry) ington	Foreign , D.C
8a-f show	Director	Usual Residence of Decedent 10a. State 10b. Coun MD Monto	•	ery		ity, Town									10d. Inside Cit	
23a or 2 st be n	al Dire	10e. Street and Number 18889 Waring S	Stat	ion Rd.	#423			Zip Code 0874				10g. C		What Cour	ntry?	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ M 3 □ Widowed 4 □ Divorce		Armed Fo 1 X Yes If Yes. Gi	2 🗌 No		I	cedent of I becify Cub 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Rica	Yes or No n, etc.)		Speci	ace - Americ ack, White, ify:Whit	etc.	
than "natu ne Medica	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	iest gra	ducation ide completed) College (1	-4or 5+)	1.	Decedent's U: (Give kind of v life. DO NOT spatche	vork done use retire	during most of work	ing				Business/Index		
ked other ic event, t	To Be Co	17. Father's Name (First, Middle Benjamin Bass	e, Last)	<u>'</u>		1 121.	Spaceric	ST.	18. Mother's Nam						VICC	
n 27 Is mar er traumat		19a. Informant's Name/Relatio Sandra O. Bass				19b. 18	Mailing Addre	ess (Street ring	and Number or Rui Station R	ral Ro	ute Numbe #423	er, City Ge	or Town	n, State, Ziji itown ,	Code) MD 20	874
ant: If iten lury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other					Disposition (A y, crematory o ndel Ci		ory 04/2	Date 1/1	09	_		City or To		
any in		21. Signature of Funeral Service	P. ;	Halt			Bever	ly L.	"Crematio Heckrott	e,	P.A.	_Cl			, MD 2	
sician edical		23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of):													veen	
miner	iner	Convertible list conditions														
ysician and e burial-trans	cal Examiner	resulting in death) Last Due to (or as a consequence of):														
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			birth 2□ Fet nant at time of	al death	3 ☐ Ectopi		су					ate of deliv		'ear
en signed by uld be deta	ρ	Part II. Other significant cond	tions c	ontributing to d	eath but not res	sulting in	the underlying	g cause giv	en in Part I.						the cause of d	
cate has ber page 2 sho	Completed										24a. Was autop perfo 1 □ Yes			prior to co death?	opsy findings a ompletion of ca	available ause of
certific irector,	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 💆 No	al	Hospital:		150/0.4		DOA Oth	26. Place of Deal							
r: After this e funeral di	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	ling stigation	28a. Date (Mon	Inpatient 2 of Injury th, Day, Year)	28b. T	<u> </u>	28c. Inju Woi	4 LI Nursing H		Describe I				ify)	
al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be rmined	28e. Place	of Injury - At h	nome, far	m, street, fact	ory, office		28f.	Location (: City or To			nber or Run	al Route Num	ber,
e Funer	Medical			niner: On the b					ime, date and place opinion, death occur)
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1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
Sta Registra	te ar	Paul M. Thamb: 31. Date filed (Month, Day, Yea	222	2009 32. F	0 / Med	ature			ve #300 R	OC.	KV111	e,	ב מנא	:0850		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar	•	artment of F r <i>tificate of I</i>			giene neg. No 2 0 0 9	14428
			Registrar 1. Decedent's Name (First, Middle, La	st)		timodio or i	- Douill	2. Date of Dea	th	3. Time of Death
	Physici /Medic		Frances	Elizabeth Co	ollinso	n		Month April	20, 2009 Year	6:35 A.M
	Examin		4a. Facility Name (If not institution, giv				r Location of Death		4c. County of De	
2			Calvert County N	ursing Center			Frederic	k	Calv	ert
Ī	Funeral		Social Security Number 6. S	Du offe		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04/29/]	(Year) 9. B	irthplace (State or Foreign Country) irginia
	Director		219-32-3329 Usual Residence of Decedent		99 Yrs.			04/29/1	1909 V	ırgınıa
	'land		10a. State 10b. County	10c. C	ity, Town or Lo	cation	_			10d. Inside City Limits
	Mary P-f sh	tor	MD Calver	t C	hesape	ake Beach				1 □ Yes 2 📉 No
	h the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What (Country?
	th wit	al [6645 Wooded Bran	nch Lane		20	732		U.S.	Α.
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show great Evant her or use to	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐Yes 2 M No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:	,,	, i	white
1215-0036	hour tural	ed b			16a, Dece	dent's Usual Occup	ation		16b. Kind of Busines	
212	i within 72 ho jiene. r than "natui	Completed	15. Decedent's Ed (Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of work	king	Tob. Time of Buomeo	or middon y
N)om	Elementary/Secondary (0-12)	College (1-4or 5+)		underwri	ter		insurance	company
0	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, Last,				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
<u>a</u>	Ment Ment arked aric e	To	Thomas Scott	Bagby			Estel:	le B	irkhead	
Maryland	2 sho	0.0	19a. Informant's Name/Relationship (**	1	_			r, City or Town, State	
a) a)	l and lealth		Francis B. Coll:	<u> </u>					peake Beac	h, MD 20732
saltimore,	nt of I		1 X Burial 2 ☐ Cremation 3 ☐	nemoval from State		sition (Name of natory or other plac	:		•	
	urtme artme rtant njury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Light						Friendship	
n n	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eveni once.	: 1	21. Signal of Furieral Service Liber	Lello au		3325 Mt. H			neral Home ings, MD	, P.A. 20736
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHRONIC O	BSTRUCT	TVE PULL	MONARY D	SERSE		Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		00000	- 1	
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	ted nsit	Examiner	Sequentially list conditions, it at y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Die to (or as a nonse.	uence cty:					ľ.
	execu n and al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					
28/60,	ificate be executed g physician and ss the burial-transit	edical		d						
Ó		/edi								
X O D	leath certific attending p for use as t	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		Ectopic pregnanc	v		23d. Date of d	
5	the all	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			Month	Day Year
Ţ.	hat the sid by detacl		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I	23e. Did to	bacco use contribute	to the cause of death?
ecords,	uires sign d be	d b		RY DISERSE	g	acrifing caree give		1 🗆 Y	_	robably 4 ☐ Unknown
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T T	he lan e has age 2	Completed						autops perfor	sy prior to med? death?	completion of cause of
\ \ \ \ \	an: T tificat tor, pa		25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26. Place of Dear		2 No 1 Ye	s 2 No
>	nysici lis cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 DOA Othe	\ /		ence 6 □Other (Sp	pecify)
vision of	ng Ph fter th neral	L:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur			ow injury occurred	33.,,,
2	rendii eath. or: A the fu	catic	2 ☐ Accident investigation				Yes 2□No			
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str ify)	eet, factory, office		28f. Location (S. City or Town	treet and Number or i n, State)	Rural Route Number,
_	pital burs a eral [29a. Certifier ertifying Ph	yslcian: To the best of my kno	owlodgo doot	a acquired at the time	mo data and place	and due to the		an atata d
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after freath: within 24 hours after freath: to the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Exam	niner: On the basis of examinations and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	date and place, and di	as stated. ue to the cause(s)
	To the comp	Me	29b. Signature and title of certifier	11 001	/	29c. Licenso		2	29d. Date signed (Mo	nth, Day, Year)
			* Dens	VII CAR	14	05	10233		04/20	12009
	1) 5		30. Name and address of person who	completed cause of death (Ite					FREDGLICIS MO	
k.K	~ ~		GLIMIS A MOOD		NOSPITT	OL DR,	4310	PRINCE	HIGOGRICIS MO	30678
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					
	riogistic		APR 2	2 2009 /2	B.	Mar. W. S.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day 1720 M 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. 1□ M 2**Z**F 9-20-1926 82 018-2**0-2**611 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 XYes 2 ☐ No MD Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4005 Welsley Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 M Married White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel James Cassidy Rachel Lockhart Johnstone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Ann Anderson daughter 1732 Peachtree Lane Bowie, MD20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Date 20c. Location - City or Town, State 20a. Method of Disposition 1基 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Nece if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Lectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 Z No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2.2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending Injury 1 ☐ Yes 2 □ No investigation

/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit P.O. Box 68760. ate has been signed by the attending page 2 should be detached for use as Division of Vital Records. certificate funeral director. this After t ours after death. neral Director: Aff filled in by the fur within 24 hours a completely

Physician

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

by Funeral Director

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than """ any highy or other traumating.

Physician

/Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of gertif

EFENSE

6 HWI

State

2

31. Date filed (Month, Day, Year)

ICHAEL

Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

IA 32. Redistrar's Signature

IW)

Registrar

			For State Registrar	State of Ma	arylan		artment of F		d Mental Hy	giene	000	14430	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat									3. Time of Death	
	Physici		Joseph Merton	,					Apri1	14, 2	Year	11:09 A M	
4	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or					r Location of De			County of Death		
	Examin	lei	1321 Anglesey Drive								ne Arun	ide1	
	irs after death w				e (In yrs.	last birthday)	If Under 1 Year	If Under 24 H Hours M				place (State or Foreign intry)	
			264-11-2868	1 X XM 2□ F	53	Yrs.	Months Days	Hours	Octobe	er 5,1	.955 F1	orida	
			Usual Residence of Decedent		10- 03	T						10d. Inside City Limits	
		ō	10a. State 10b. County		100. 011	y, Town or Lo						1 ☐ Yes 2XXNo	
		Director	Maryland Anne An	rundel		Davi	dsonville	9		10a Citiz	zen of What Cou		
		ä	1321 Anglesey Dri	V.O.			210	05		US			
		era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V			(Specify Yes or N		A. Race - Ameri	ican Indian.	
		Funeral	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 □ No						(Specify Yes or N lerto Rican, etc.)	1	Black, White,	etc.	
036		þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:	If Yes, GiveAA			1 ∐Yes 2 ∭Mo <i>Specify:</i>			Specify: White		
21215-0036	2 ho	Completed	15. Decedent's E	ducation			dent's Usual Occup		working	16b. Kin	nd of Business/Ir	ndustry	
21	thin 7		(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retire	d)	WORKING	Bui 1	ding Su	nn1	
2	er th	Ço	12	5		Vice	Preside					тррту	
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yla	should be filed within nd Mental Hygiene. marked other than matic event, it.		Joseph Andrew (T		L	leve Mary				
Maryland	12 sho h and risuma		19a. Informant's Name/Relationship	,					Rural Route Num				
	l and leaf		Debra D.Carson/ 20a. Method of Disposition	Wife	20h F	1321	Anglesey	, Drive,	Davidso	nvill	e, Md	21035 own State	
آور	Pages 1 nent of 8 ant: If ite		1 ABurial 2 ☐ Cremation 3 [T							e, Maryland	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		4 □ Donation 5 □ Other (Special Signature of Fuheral Service Rice	• •	La	Kellont	Name and Addre	ardens	George P.	Kala	s Finer	al Home	
Ba			21. Signature of Funeral Service Little	100					land Rd.				
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
	Physician /Medical		shock, or heart failure. List only one cause on each line. Onset a Onset a									Onset and Death	
			resulting in death) Due to (or as a consequence of):								7/2000		
	Examiner												
	D #=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C										
	ecute and trans	Examiner											
,092	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):										
87		dical	•	d									
Вох 68		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date of delivery		
Bo		cian	in the past 12 months?							Month		Day Year	
P.O.		ed by Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown										
σ,			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did	I tobacco us	co use contribute to the cause of death?		
of Vital Records,									1	Yes 2			
တ္ထ		Completed								24a. Was an 24b. W		ere autopsy findings available	
æ	The law cate has page 2 s	E							per	opsy formed2 2 No	death?	ompletion of cause of	
ital	i clan: Th certificate ector, pag	0	25. Was case referred to medical examiner?					26. Place of I	Death (Check only	/			
5	Physician this certifi al director,	To B	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗌	ER/Outpatie	nt 3 □ DOA Oth	ner: 4 🗆 Nursin	g Home 5 Re	sidence 6	□Other (Spec	oify)	
0	ding After fune		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of linjury 28c. Injury at Work?				28d. Describe	28d. Describe how injury occurred				
Sio		cati	2 Accident investigation 3 Suicide 6 Could not	00			M 1 ☐ Yes 2 ☐ No		2011				
Division	or At after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the		29a. Certifier 1X Certifying F	hysician: To the best	of my kno	owledge, deat	h occurred at the t	ime, date and p	lace, and due to the	ne cause(s)	and manner as	stated.	
		Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
_	To To Con	Σ									29d. Date signed (Month, Day, Year)		
5. D. Dafabaur, M.D. 053070							4/15/2009						
1	SCOP,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John J. Hopkins Hapital 1650 Orleans St. Room 689, Balt, MD 2123 State Registrar APR 17 2009 State APR 17 2009 Registrar's Signature APR 17 2009 Registrar's Signature APR 18 2009 Registrar's Signature APR 18 2009 Registrar's Signature APR 18 2009 Registrar's Signature APR 18 2009								D 2/23/			
State 31. Date filed (Month, Day, Year) 32. Re						Registrar's Signature							
	Registr	ar	APR T.A	4000 per		1. 17							

Registrar DHMH 17 Rev 1/2001

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Physicia		Registrar 1. Decedent's Name (First, Middl	le,Last)				- "-	2. Date of Dear	th	3. Time of Death		
Medical Exami	ner	E. Katheryn Clark							Day Year 09	0810 hrs		
			a. Facility Name (if not institution, give street and number) 4 1260 Defense Highway				c. City, Town, or Location of Death Gambrills 4c. County of Death Anne Arundel					
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye			th (MM/DD/YYYY) S	3. Birthplace (State or Foreign Country)		
Director		562-22-6372 1 M 2 X F 85 Yr				Months Da	ys Hours	Feb. 1	1, 1924	Iowa		
ý		Usual Residence of Decedent 10a. State 10b. County		100 City 1	Town or Locat	ion				10d. Inside City Limits		
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larylar 28a-f s at on	ecto	10e. Street and Number	TIT GIIG CX	Joanne	LILLE	10f. Zip Code 10g. Citizen of What Country?						
ith the Maryland 23a or 28a-f show notified at once.	ä	1260 Defense H	lighway			21054 USA						
h with	Funeral Director	Armed Former 16 V				is Decedent of H		American Indian, Black, etc.				
r deat or ite	To Be Completed by Fun	XX Yes 2 No				Yes $2\overline{X}$ No specify:			Specify: White			
rs afte		3 X Widowed 4 Div	or Dates:	<u> </u>	,	Yes 2 X N		of work done	16b. Kind of Busin			
2 hou		Elementary/Secondary (0-12)		1-4 or 5+)		ost of working lif				,		
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5-0 lled w Hygie I other		17. Father's Name (First, Middle	, Last)				18.Mother's N	ame (First, Middle, I	Maiden Surname)			
21215-0036 und be filed within 7 Mental Hygiene. marked other than e event, the Medica		Horace Brenton			Table Basilia	. Add (0)		Schmidt	mber, City or Town,	Clade Zie Cade)		
MD 2 nd 2 shoul alth and N m 27 is m anmatic		19a. Informant's Name/Relations				(Dale, MD			
and 2 and 2 Health item 2		Diane Clark/ I	augnter		lace of Dispos	sition (Name of c		Date		ity or Town, State		
10fe ages nt of h		1 X Burial 2 Cremation		rom State	rematory or ot Arling t	^{her place)} :on <u>Cemeter</u>	0,	5 /08/200	9 . 1	77.4		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Signature of Funeral Service		I Nat	22. I	Cemeter Name and Addres	ss of Facility R		I TIT TITLE	neral Home		
Injiri III Dep		De fitzer			1 16	000 Ann	apolis	Road Bowi	ie, MD 20	715		
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death.	Do not enter t	he mode of dying	g, such as cardi	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
/Medical xaminer	Н	Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):										
7		h										
	I Examiner	Sequentially list conditions, if any, leading to immediate										
		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.										
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Box 68760, e death certificate be exc the attending physician ed for use as the burial-	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in the	00	outcome of pregn	_				23d. Date of de			
C 68 certif	ciar	past 12 months?	L	nant at time of dea	th Z	etal death 3 ther (Specify)	Ectopic pre	egnancy	Month	Day Year		
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ords, P.C w requires that as been signed be seen	ted	24a, Was an 24b, We								ere autopsy findings available		
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Vital ysician:	Be c	examiner?	Hospital:	Inpatient 2	ER/Outpatien		Othor	ursing Home 5	Residence 6 🗸	Other: Scene		
1 of Vital Recting Physician: The After this certificate funeral director, page	n: To	27. Manner of Death	28a. Date	e of Injury th, Day,Year)	28b. Time of	Injury 28c. In	jury at Work?	28d. Describe	how injury occurred	ı		
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D ospital hours meral		4 Homicide determined (Specify)										
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To the within To the compl		and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	7	OLITAZ .				0.0	C.M.E.		April 9, 2009	April 9, 2009		
W.W	\mathcal{V}	30. Name and address of person who completed cause of death (Item 23a)										
0/1/2			sistant Medical			Street, Baltim	nore, MD 21	201				
St Regist	ate	31. Date filed (Month, Day Year)	2009	Registrar's Signatu	ba	Kel						
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DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Patricia Lee Carey April 16, 2009 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Arunde1 If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F 215-72-7349 50 20, 1959 Virginia Director Jan. Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat neural be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Director Prince George's Maryland Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2214 Hindle Lane 20716 Funeral S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Food Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Lee Satterfield Kathleen B. Thomas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John R. Carey/Husband 2214 Hindle Lane, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 4/20/2009 | Davidsonville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1/2 /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque de of) Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. sate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate **Division of Vital** 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 **1**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ie Hospital or Attending Pl 124 hours after death. ie Funeral Director: After t 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestsate Rd Ste 300 Annapolis mo 2144 900 MD 31. Date filed (Month, Day, Year) Registrar's Signature APR 17 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13- 2009 **Physician** Lesine Raymond Carter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death upper Mariboro Prince Georg 12416 Cecily Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-58-3446 Days 1 M 2□ F 63 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Mudical Examiner must be notified at MD Prince Georges 1 Yes 2 No Upper mariboro Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 12416 Cecily Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Bres 2 No If Yes, Give Year or Dates: 1968-1974 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Private Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver 12+10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) carter Willard E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is in any injury or other traum once. Cynthia stewart carter/wite 12416 cecily ct upper mariboro, mb 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State Che Hennam, MD maryland Veterans (em. 04-23-09 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S Bianchi 814 upsnur 3+ NW Wash, DC acoll 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ischemic Heart Discase Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an Yes To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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State

Registrar

M. Tagour. MD 31. Date filed (Month, Day, Year) APR 2 2 2009

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32. Registrar's Signature

Mujour.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician CONNER CATHERINE Μ. April 20 2009 3:30 A /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 15, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days 1 M 200 F 80 579-38-1122 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Events 200 once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 XXNo **Funeral Director** Prince George's Accokeek Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street end Number USA 14815 Fort Trail 20607 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 □Yes 2\No Specify Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. News & World Report Secretary 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Lest) Be Catherine Α. Morrissev William Α. Devine ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Conner / Husband 14815 Fort Trail Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Ch. Cemetery 20c. Location - Cify or Town, State 20a. Method of Disposition ₩X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/23/2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee Lels Z 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** 10 years **EMPHYSEMA** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical ‡ ate has been signed by the attendir page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2.XXVo Certification: To 1 XXnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the .
within 24 hour.
To the Funeral D' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4/22/2009 D39691

Registrar
DHMH 17 Rev 1/2001

State

4467 Old Branch Avenue

32. Registrar's Signature

#201 Temple Hills, Maryland

20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Redjaee MD

APR 2 2 2009

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gisele Α. Chapo Year **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Vi comi HOSPICE If Under 1 Year | If Under 24 Hrs. | B. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1□M 2**√**F Hours 141-32-8906 80 Director 05/03/1928 Serbia Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the firstlich Exactive must be notified at 1 ☐ Yes 2 ☐ No Director Princess Anne Somerset Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21853 USA 28271 Mt. Vernon Road Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after alth and Mental Hygiene.
27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify: white 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) research assistant medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Sandor Kedves Anna Sagi ပ 19a. Informant's Name/Relationship (Type. Print)
Steve Chapo/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28271 Mt. Vernon Rd., Princess Anne, MD 21853 Baltimore, Department of Heal Important: If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/21/09 Salisbury, MD Salisbury Crematory Name and Address of Facility Holloway Funeral Home Professional Associaiton 21. Signature, of Funeral Service Lice Talla Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KRNAL **Physician** END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) ned by the a detached f 9 Hillnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 2 No 3 Probably 4 Unknown 1 Tes Completed been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1 ☐Yes 2 🗸 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) 1☐ Yes 2/2 No ဥ 2 ER/Outpatient 3 DOA 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00052410 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

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APR 2 1 2009

31. Date filed (Month, Day, Year)

Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Catherine Driscoll April 18 2009 9:00 AM M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 12053 Bayswater Court Charles Waldorf 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1937 New York 1 □ M 2 X F Months Days Hours Min. 71 130-28-4929 Usual Residence of Decedent 10a. State 10h County 10c, City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12053 Bayswater Court 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 X No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th. Custodian S.I.E.U. Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Foy Margaret Hickey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathleen Driscoll/ Daughter</u> <u>12053 Bayswater Ct. Waldorf, Maryland, 20602</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Charles Cemetery April 27, 2009 Farmingdale, N.Y. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licer 3035 Old Washington Rd. Waldorf, MD., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) €. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, signed by the a d be detached f certificate has been si rector, page 2 should director, this neral Director: A filled in by the fi

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Examine

Physician/Medical

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Be Completed

Certification: To

Medical

29b. Signature and title of certifier

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It with Acal Examinating to notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

/Medical

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (sp			Month Day Year		
Part II. Other significant conditions	contributing to death but not resulting in	in the underlying ca	ause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?		
100				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DC	Other: 4 I Nursing H	lome 5 Residence	6 ☐ Other (Specify)		
27. Manner of Death 1	(Month, Day, Year)	Time of Injury M	8c. Injury at Work? 1 ∐ Yes 2 ∐ No	28d. Describe how injur	y occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		arm, street, factory	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 ☐ Certifying F (Check only one) 1 ☐ Certifying F 2 ☐ Medicai Exa	Physician: To the best of my knowledgraminer: On the basis of examination are and manner stated.	e, death occurred nd/or investigation,	at the time, date and plac , in my opinion, death occ	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the cause(s)		

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ⊀ 20666 0 31. Date filed (Month, Day, Year Degistrar's Signature APR 21

29c. License number

29d. Date signed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760,

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/Medio		4a. Facility Name (If not instituti				4h City Town o	r Location of Deat			nty of Death	
Examin	er	1101 Kennebe					Hill				eorges
		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	If Under 24 Hrs.	8, Date of Birt			place (State or Foreign
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EEE		19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	g Address (Street			er, City or Tov	ın, State, Zij	p Code)
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ding physician and se as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to d. 23c. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Veal **Physician** NEIL G. EDGELL JR April 7,2009 710 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur Wicomico Salisbury Rehabilitation + Nursing Ctr If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 08-25-1944 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 64 222-28-4830 Delaware Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, The Medical Examiner must be notified at 1 XYes 2 No Director Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 US 59 Long Meadow Dr Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Inportant: If Item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specifywhite <u>م</u> 3 Widowed AD Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Technology Computer Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Neil G. Edgell Sr Virginia Rawlins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharlana Edgell - sister 24320 Greenbriar Lane, Seaford, dE 19973 timore, 20b. Place of Disposition (Name of St. Johnstown Cem. 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20c. Location - City or Town, State Date 04/20/2009 Greenwood, 4 □ Donation 5 □ Other (Specify) Cranston Funeral Home P O Box 967, Seaford, 21. Sign ture of Fureral Strvice Lic Cranston John A. DE 19973 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each rine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 G BET disease or condition resulting in death) /Medical as a consequence of Examiner 4 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 110 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ⊡ Me 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: /
pletely filled in by the f 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examine/: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the companion of the compani 29a. Certifier Medical ? On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of cortified

31. Date filed (Month, Day, Year)

William H. Robins

APR 2 1 2009

within 2.

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

M.D

32. Redistrar's Signature

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene									
- For State Registrar	Certificate o	of Death		Reg. N			1 mb 100 stb		
Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time o	f Death		
	ERIC WILLIAM FRAZ	IER		April 27, 2009	y Year	1655	hrs		
4a. Facility Name (if not institution, give s	treet and number)	4b. City, Town, or Location of Death			4c. County of Dea	ath			
8142 Apples Church Road		Thurmont			Frederick				
	I make the second second second	If Under 4 Vees	If I Indas 24Hea	O Date of Birth (Rithnlace (St	rate or		

			I- For State	o or maryland	Cer	tificate of D	eath		Reg. No.	20	U9 1441
Me'c _l :	Physicia ' Exami	an/	Decedent's Name (First, Middle,L		ILLIA	M FRAZIE	R	2. Date of D Month April 27,		Year	3. Time of Death 1655 hrs
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	any		Usual Residence of Decedent 10a. State 10b. County			Town or Location					10d. Inside City Limits
7	vith the Maryland s 23a or 28a-f show s notified at once.	ģ	Maryland Freder	ick	Thu	rmont	Of. Zip Code		10a Citizen	of What Coun	1 Yes 2 X No
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	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medic I Examiner must be notified at once.	uneral	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent Armed Forces? 1 Yes 2			ecedent of Hispanic O specify Cuban, Mexica	rigin? (Specify Yes or an, Puerto Rican, etc.)	No- 14.	Race - Americ White, etc.	can Indian, Black,
	s after d ral", or	by F	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:			es 2 X No specifi Usual Occupation (Giv			ecify: Whi	
"	ld be filed within 72 hours afte dental Hygiene narked other than "natural", event, the Medic I Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or		during mos	of working life. DO NO	oT use retired)			ŕ
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215	be filed antal Hy arked of	Be	Lamont Edward F	razier				nna Shirle			
MD 21	2 should 1 and Me 27 is ma matic e	2	19a. Informant's Name/Relationship Carl E., Frazier		ther	-	•	umber or Rural Route Drive, Fre			
<u>ح</u> نه	ages I and 2 shoul nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St	ate	crematory or othe		Date		cation - City or	
fimore	t. Page tment c rtant: y or oth		4 Donation 5 Other Spec	ify:	Sm		Crematory				Maryland
Balti	permit. Depart Impor injury		27. Signature of Funeral Service Cit 23a. Part I. Enter the disease, or do	V=> //	4	КОВЕ -615	ŘÍ É. DAIĽ EAST MAIN	EY & SON F	JNERAL IRMONT	HOMES,	
P	hysician 1edical		23a. Part I. Enter the disease, or co failure. List only one cause on	each line.				s cardiac or respiratory	arrest, shock	, or heart	Approximate Interval Between Onset and Death
	.aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			1				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence o	of):					
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760	cate be executed physician and the burial - transi	Medica	X UNPENDED IF FEMALE:	AMENDED 23 9 per fh 23c. If yes, outco	g89	1 5-22-	9 vt	3/0/07 11	23d. I	Date of deliver	у
8	certific ending puse as th	ician/	23b, Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a		2 Feta	death 3 Ector (Specify)	opic pregnancy	М	lonth [Day Year
R _O X	ing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physi	1 Yes 2 No 9 Unknot	9 Olikilowii	th but not		derlying cause given in	Part I 23e D	d tobacco us	e contribute to	the cause of death?
٥	res that the signed be detacted	þ	- art ii. Other significant condition	to contributing to dea	ar bat not i		activities occord gives in		Yes 2	No 3 Prof	bably 4 Vunknown
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ے د	ospital hours a meral I	ပ	4 Homicide determ	ined (Specify)				Thur	mont,	MD	les Church R
(1/0)2	To the Hospital or Attending Physician: The law requires that the death certifications and thous after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Medical	Charle and Certifying Phy	sician: To the best of r ner:On the basis of exa and manner stated	amination .	age, death occurre and/or investigatio	n, in my opinion, death	occurred at the time, o	ate and place	and due to the	he cause(s)
	F % F 8	Me	29b. Signature and title of certifier \mathcal{W} ,	mp			29c. License numb	per		ate signed <i>(Mo</i>	onth, Day,Year)
			30. Name and address of person w				Baltimore. MD 2	1201			

32. Registrar's Signature

parker ORIGINAL

State

Registrar

Registrar

DHMH 17 Rev 1/2001

State

GITW. MARPHAIL BULL SIN MA 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPAMO

82. Registrar's Signature

DUFRED

MAY 0 5 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea **Physician** 7:30 Rose Leah **Goldstein** 17 2009 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homecrest Assisted Living Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗷 F Yrs. Director 85 065-18-4446 June 22, 1923 Illinois Usual Residence of Decedent Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Director 1 □Yes 2 Tx No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with "natural", or items 23a or vast be 3605 Stoney Castle Street 20832 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after ament of Health and Mental Hygiene.
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Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 04/21/2009 Olney, Maryland 21. Signature of Funeral Service Li ensee 22. Name and Address of Facility Nanc Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause in Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of Incidence of **Physician** disease ndition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. Tun., Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 X No 2 □ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Assisted Living 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: # М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exam 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D38457 April 20, 2009 30. Name and address of person wit / complet of cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Nakul Goyal, M.D.,

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31. Date filed (Month, Day, Year)

edistrar's Signatui

3801 International Drive, Suite 211, Silver Spring, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1^D7, 2009 April Gianaris 11:00a^M Mary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12101 Connecticut Avenue Wheaton Montgomery 8. Date of Birth 9. Birthplace (State or Foreign Sept Day 2 9 1 4 County as h., DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 94 578-07-8811 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Exercitor roust by notified at MD Director Wheaton Montgomery 1 ☐ Yes 2 X No 10f. Zip Code 20902 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in the filed of Health and Mental Hygiene. It if them 27 is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Exercises on the traumatic event, the Medical Exercises on the traumatic event, the Medical Exercises. 12101 Connecticut Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. □Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 □Yes 2 X No Specify Specify: ģ 3 ☐ Widowed 4 A Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Koutsoukos Peggy Kontos 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Thornberg/Daughter 12101 Connecticut Ave.Wheaton,Md.20902 permit. Pages 1 and Department of Health Important; If Item 27 any injury or other trong. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Bernoval from State Ft.Lincoln Cem. 4/21/2009 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Funeral Service PHILIPAGOS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, ner Due to (or as a consequence of) If any, leading to min solid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-transit Physician/Medical Exami and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mild renal insufficiency autopsy performed?
Yes 2 2 No page 2 certificate 1 ☐ Yes 2 ☐ No mild diabetes
25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: / 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🛿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 20,2009 3 DC13325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Miller MD 2440 M Street NW Suite 810 Wash., DC 20037 31. Date filed (Month, Bay, Year) Registrar's Signatur

DHMH 17 Rev 1/2001

Registrar

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altimore,	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St	ate 20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Loca	ation - City or T	Fown, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eleanor Small Gates 7:20a M April 19, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-34-4753 Months Days 1 □ M 2 🕱 F 81 Director February 13, 1928 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wedical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 2 XNo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Emmet Road Funeral 20902 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 **XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 7 Private Physician Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Norris Small ပ Berneice Dray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Edward Gates / Husband 2713 Emmet Road, Silver Spring, MD 20902 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2XXCremation 3 ☐ Removal from State April 22, 2009 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10001 /Medical Due to (or as consequence f): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Examin sician and burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2XXNo Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Coronary Artery Disease page 2 should Be Completed Rheumatoid Arthritis 240 14/00 00 24h Were autoney findings available Certification: To

Division of Vital Records, P.O. Box 68760, filled in by Funeral the within To the မ

				autopsy performed?	prior to completion of cause of death? 1 □ Yes 2 ☒ No				
25. Was case referred to medical examiner?	1	26. Place of Death (Check only one)							
1 Yes 2 XNo	Hospital: 1XXInpatient 2	Hospital: 1XXInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othe							
27. Manner of Death 1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	28b. Time of lnjury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury	occurred				
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		nome, farm, street, factory, o	office 28	If. Location (Street and City or Town, State)	l Number or Rural Route Number,				
29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the best of my kn Examiner: On the basis of examin	owledge, death occurred at ation and/or investigation, i	the time, date and place, and my opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)				

10

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

Rahmania

D66372

April 20, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanian 31. Date filed (Month, Day, Year) 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar



09-03388 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wayne Goldstein State of Maryland / Department of Health and Mental Hygiene 2009 14446 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 1135 hrs Wayne M. Goldstein Medical Examiner April 27, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Hospital Rockville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Min Director 213-50-3071 1 X M 2 Yrs 56 8 1952 Wash Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10b. County 1 X Yes 2 No or 28a-f show iten 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examin r must be notified at once Maryland Montgomery Kensington with the Maryland 10g. Citizen of What Country? Direct 10f. Zip Code 10e. Street and Number 3009 Jennings Road 20895 U. S. A. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces? 2 X No Yes White Divorced Give Yea Yes 2 X No specify Specify Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) bernit. Pages I and 2 should be filed within 72 hour epartment of Health and Mental Hygene. portant: If item 27 is marked of ury or other transment. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Years Elementary/Secondary (0-12) Landscape Artist/Civic Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dr. Lloyd Goldstein Trenice Dodek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Trenice Goldstein - Mother 3400 Pauline Drive, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Garden of Remembrance Memorial Park 1 X Burial 2 Cremation 3 Removal from State May 1, 2009 Clarksburg, Md. Donation 5 Other Specify: ^{22. Name and Address of Facility}
Danzansky—Goldberg Memorial Chapels
1170 Rockville Pike, Rockville, Md. 21. Signature of Funeral Service Licensee 564 20852 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complication failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and **Vedical** Death Hypertesnive atheroscleortic cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical AMENDED 23a, 27, perME, g891 5/6/09 TT X UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 V Yes 2 No 26.Place of Death (Check only one) director, 25. Was case referred to medica Be Other₄ examiner? Hospital: Inpatient 2 V ER/Outpatient Nursing Home 5 3 Residence 6 1 ✓ Yes ٩ funeral 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural Yes 2 Pending the Funeral Director; the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 20 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe April 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year State APR

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

4b. City, Town, or Location of Death

Clinton

GILCHRIST

2. Date of Death

April

16, Day 2009

4c. County of Death

Prince George's

3. Time of Death

3:30

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)
Clinton Nursing Home

WILLIE

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland sent of Heatth and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show rit: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

bermit. Pages
Department of F
Important: If ite
any injury or of
Once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 20, 1 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number Days Months Hours 1 □ M 2 👿 F 248-62-1596 72 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Charles 1 ☐ Yes 2 X No Waldorf Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2322 Alava Court 20603 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No ģ 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erskin Ford Allean S. Gerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Johnson / Son 2322 Alava Court, Waldorf, Maryland, 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State Graceland Mem. Park 04/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Kenilworth, New Jersey 3035 01d Washington Road 22. Name and Address of Facility 21. Signature of Euperal Service Licens e Huntt Funeral Home Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final COROHARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mulutur antes. 04-16-2009 D0048123

Registrar
DHMH 17 Rev 1/2001

State

750

CLINTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRC ANTWI - DONKOR

ROAD

32. Registrar's Signature

PISCATA WAY

31. Date filed (Month, Day, Year)

SUITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 1¹3^y, 200^o5^r 7:25 AM James Joseph Gough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall Saint Marys If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F Months Days Hours 132-03-6894 90 Director 2/20/1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21409 USA 10 Arlie Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ၨANo If Yes, Give Year or Dates: Specify: Specify: White 3XXWidowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer US Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Elizabeth Roche James Joseph Gough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1433 Thornbury Court, Crofton, MD 21114 Marie Glennon - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/18/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u> Hillcrest Memorial Gardens</u> 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility John M. Taylor Funeral Home, Inc Mycles T. Klokei 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALZHE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' death? 1 □ Yes 2 □ No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner-of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, P.O. Box 68760, Division of Vital

I or Attending Physician; The law requires that the death certificate be executed after death.
I blirector: After this certificate has been signed by the attending physician and of Director. After this certificate has been signed by the attending physician and of office of the transition. filled in by To the Hospital o within 24 hours af To the Funeral Di completely

> 6-1 State Registrar

4 Homicide

29b. Signature and title of certifie

29a. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67788

29d. Date signed (Month, Day, Year)

13.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI

29449 Charlotte Hall Road

Charlotte Hall, MD 20622

31. Date filed (Month, Day, Year) 82. Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and
Divisi	To the Hospital or Attendir within 24 hours after death.	To the Funeral Director:
	7+	-/

		Please Type or Print		delible ink. Ens artment of Health	11157	_			
		For State Of Ma. State Registrar		rtificate of Death	_	Reg. No. 2	14450		
		Decedent's Name (First, Middle, Last)			2. Date of De.		3. Time of Death		
Physicia /Medic		Kenneth Melvin Gent			April	17, 2009	10:30 P M		
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		4c. County of Deat	h		
Funeral		Dove House 5. Social Security Number 6. Sex 7. Age 1 ☑ M 2 ☐ F 1 ☑ M 2 ☐ F	(In yrs. last birthday)		er 24 Hrs. 8 Date of Bir	th 9. Birt	hplace (State or Foreign		
Director		220-24-6325	81 Yrs.	Months Days Hours	Min. (Month, Da Dec 15	, 1927 Mar	yland		
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits		
Maryt	tor	MD Carroll 1	Hampstead				1 ∐ Yes 2∭ No		
th the	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?		
s 23a	ral	3827 St. Paul Road		21074		USA			
ter de	Fune	11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Example Forces? 1 □ Never Married 2 Married)	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	origin? (Specify Yes or No an, Puerto Rican, etc.)	- 14. Race - Ame Black, White			
ral", or	þ	If Vac Cive	1946–48	1 □Yes 2X No <i>Specif</i>	<i>y</i> :	Specify: W	hite		
72 hc "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Business/	Industry		
within lene. than		Elementary/Secondary (0-12) College (1-4or 5+)	r Equipment Me		Heavy Equi	pment Repair		
e filed Il Hygi other /ent, I	Be C	17. Father's Name (First, Middle, Last)		18. Mot	her's Name (First, Middle	Maiden Surname)	•		
Menta Menta arked atic e	70 E	Russell Melvin Gent		Doro	othy Louise	McFadden			
and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygene. n 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Modical Evertiner must be notified at		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Num			Zip Code)		
Heali Heali tem 2		Susan Johnson/daughter 20a. Method of Disposition	20b. Place of Dispo	St. Paul Road	Date Date	20c. Location - City or	Town, State		
Pages nent of nt: If I		1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)	04/21/09	Odenton, M	D		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Evertires must be notified at once.		21. Signature of Funeral Service Licensee		ing while che					
ED = 60	\neg	23a. Part 1. Enter the disease, or complications that caused to		everly L. Heck			Approximate		
Physician		shock, or heart failure. List only one cause on each line	ocardial I				Interval Between Onset and Death		
/Medical -		resulting in death) Due to (or as a	consequence of):						
	e.	Sequentially list conditions, if any leading to immediate	ascular Ac	cident					
cuted nd ansit	Examiner	usé. Enter Underlying use (Disease or injury t initiated events Dementia							
e be executed sician and e burial-transit	al Ex	resulting in death) Last Due to (or as a	consequence of):						
ficate t physic s the b		d							
eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o		75		23d. Date of de	livery		
e deatl he atte	Physician/Medi	in the past 12 months? 1 Yes 2 No 1 Independent at 1		Ctopic pregnancy Other (specify)		Month	Day Year		
that the de led by the a detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Par	t1. 23e. Did 1	obacco use contribute to	the cause of death?		
The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	d by					Yes 2□No 3□P	robably 4X Unknown		
e law red has bee ie 2 shou	Completed				24a. Was		utopsy findings available completion of cause of		
	Com				perfo 1 □ Yes	ormed? death?	s 2□No		
Physiclan: r this certific ral director, I	Be	25. Was case referred to medical examiner? 1 Divers 2 VINe Hospital:			ce of Death (Check only o				
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Attending is death. ector: After by the fune	atio	1 X Natural 5 □ Pending (Month, Day, 2 □ Accident investigation	Year) Injury	M 1 ☐ Yes 2	□No				
I or Attendi after death. Director: A	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office	28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,		
spital		29a. Certifier 1X Certifying Physician: To the best of	f my knowledge, deat	h occurred at the time, date	and place, and due to the	cause(s) and manner a	s stated.		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner state		29c. License numbe					
C o o		29b. Signature and title porcertifier	MD	D54218		29d. Date signed <i>(Moni</i> April 20, 2			
741,		30. Name and address of person who completed cause of de			∽ MD 21157				
Sta	te	Raman B. Kaneria, M.D. 349 I	MALCOLIN DE	. wesulthstel	L, PID 2115/				
Registra	ar	MFR 2 2 2009 Kgum	N 12. A	are					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALBERT WARE GREAVES, JR. 2009 6023M 20 mi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eas ton Hospita memorial talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X**M 2□ F Days Hours Min. MARYLAND Months 93 218-30-0911 JAN.5,1916 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MARYLAND QUEEN ANNE'S QUEENSTOWN Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21658 UNITED STATES 312 PIG PEN POINT ROAD Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 6 1 □Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 Divorced Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
any Injury or other traumatic event, the Modical Existance. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARM MANAGER AGRICULTURE Pages 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNE L. WOOLFORD ALBERT WARE GREAVES မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE GREAVES/WIFE 312 PIG PEN POINT ROAD, QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of Cemeter, crematory or other place)
OLD WYE CHURCH
CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WYE MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ABDOMINAL hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclero Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Ye ar 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown certificate has been signed rector, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by schythmia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check onl. one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Medical 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31867

Q

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int \) Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:04 PM 2009 langue Cens /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 X F 88 MARYLAND 215-18-460 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No MARULAND Director 1, comico UAN 1: CO 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? NEDO 21856 5556 USA Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retifed) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) Domes NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental 27 is marked c traumatic eve Se Hemas hurch ANN'E HANDY SAMUE မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 since Department of Health an Important: If item 27 is any injury or other trauonce. FA DENEASE Aughter Bex BUHANNE 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date ☐ Donation 5 ☐ Other (Specify) EM 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WAR TUNERA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** emorrhagic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) 1 Yes 2 No Unknown the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has perform 2 **X**No 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 🗌 DOA မ funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 Yes 2 No ours after death.

eral Director: Af
filled in by the fu Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 🗌 Homicide within 24 hours a

To the Funeral D

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (check only one) and manner stated To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETIMBER 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year State Bark

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL 14, JOANNE PALMER HOUSTON 2009 0648 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Jan.21,1954 55 Director 577-76-6245 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examinar must be notified at Yes 2□No Director MD Montgomerv Gaithersburg death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 15-B Waters Street 20877 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes ②☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 'nent of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Receptionist Urologist Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester B. Lewis Margarite 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Houston (Husband) 15-B Waters St, Gaithersburg, MD 20877 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem 4/25/09 Gate 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Lice lorge 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Acute Hepatic Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed Cirrhosis of Liver use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Metabolic Encephalapathy attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. s been signe should be d Anemia 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an certificate has page 2 s autopsy performed? 2 No 1 ∐Yes 2 No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Matural 5 ☐ Pending investigation Jo the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4/14/09 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Vinu Ganti, M.D.

21

31. Date filed (Month, Day, Year)

Registrar's Signature

19529 Doctors Drive, Germantown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Barbara Ann Harris 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARL JVISTA MEDICAL NTA If Under 24 Hrs. st birthday) Social Security Number Birthplace (State or Foreign Country) Year) Days 1 ☐ M 2 💢 F 70 462-72-9655 **Director** 11, 193B West Virginia Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 □Yes 2 No Director Maryland Charles Waldorf Harris, Barbara Mitissalle timore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3038 Churchill Ct. 20601 U.S.A. by Funeral Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Marical Examination once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ∐Yes 27√2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Sorrell Sallie Wilson ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Harris Husband 3038 Churchill Ct., Waldorf, Maryland 20601 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria, Virginia 21. Signature of Funeral Pervice License 22. Name and Address of Facility
Williams Funeral Home, P..A. 899COM 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the dis shock, or heart fail e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Fina neumonal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to mine data cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 ZNO 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2XNo 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10061652 200 Name and address of person who co cause of death (Item 23a) (Type, Print) wite 101 Waldorf, Md 2060 1057

DHMH 17 Rev 1/2001

State Registrar Day.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Physician Kathryn E. Hinchliffe April 18, 10:10 P^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Solomons Nursing Center Calvert Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 8, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 98 Texas 579-22-5588 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene.
77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Charles Swan Point 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a (11260 Keokee Court 20645 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public School School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Burnham Emma Buzzard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Richard W. Hinchliffe / Son 11260 Keokee Court, Swan Point, Maryland 20645 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory April 20, 2009 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Ligensee SK 5 P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** many years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 es 2 No 3 Probably 4 Unknown CVA, HTN, COPD Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

within 24

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scaria Mathew, MD 11840 H.G. Trueman_Road, Lusby, Maryland 20657 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature Deneura 2009 ▶

and manner stated.

parke

29c. License number

D 3 6969

29d. Date signed (Month, Day, Year)

412010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HILBERT **Physician** ARGUERITE MYLINE 061 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Year) Days 176-05-1750 1 M 2 F 94 1915 Pennsylvania Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylai ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, I'm Model Exp., inclustes to nother than an Maryland Anne Arundel 1√EXYes 2 □ No Director Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 100 Severn Avenue, #306 21403 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin J. Morelock Sadie Yost ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Hilbert/husband 100 Severn Avenue, #306 Annapolis, Maryland 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or or 12 Surial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 4/21/2009 | Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of); mostlud Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Ö ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy certificate 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division or Attending 5 ☐ Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

24 hours after on Funeral Direct Hospital within 2

> State Registrar

Date filed (Month, Day,

(Check only one)

29b. Signature and title of ce

and manner stated

ne and address of person who completed cause of death (Item 23a) (Type Print) ENSE EN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	_		1 - State Registrar	Ce	rtificate of	Death	Reg	Reg. No.2 0 0 9 1445 /		
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of E Month			n Day Year		
-	/Media		Lillian Gorelick Hack				4/16	2009	8pm ™	
	Examir	ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Deat	h	
5-1	Funeval		Anne Arundel Medical Cente 5. Social Security Number 6. Sex 7. Ac	r le (In yrs. last birthday)		apolis If Under 24 Hrs. T	8 Date of Righ	Anne Arur	ide1 hplace (State or Foreign	
н	Funeral Director		213-14-9480 1□M 255xF	87 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 1/13/192	ear) Co	untry) MD	
			Usual Residence of Decedent				1/13/172		110	
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	with the	٦	10e. Street and Number		10f. Zip Code		10g	Citizen of What Co	•	
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8	al",o	by	3 ★Widowed 4 Divorced If Yes, Give Year or Dates:		1∐Yes 2∏No	Specify:		Specify:	White	
15-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Exercitive to ust be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of workir	161	o. Kind of Business/	ndustry	
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22	Hygie Hygie Iher t		12 17. Father's Name (First, Middle, Last)		Owner	40.14.11.1.11		Retail		
an	d be f	Be	Harry Gorelick			18. Mother's Name Jennie El	(First, Middle, Mai herinberg	,		
Maryland 21	should nd Me mark matk	은	19a. Informant's Name/Relationship (Type, Print)	10h Mailir	ng Address (Street	and Number or Rura		·	in Cadal	
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ē,	s 1 al		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	ike Rd. Ar		MD Z1401 Location - City or	Town, State	
altimore,	Page nent c int: If iry or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Kneseth	_		/2009 A	nnapolis,	MD	
<u>=</u>	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "any Injury or other traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic event, in "the traumatic	13	21. Signature of Funeral Service Licensee	22	2. Name and Addres	s of Facility Har				
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1	Physician		Immediate Cause (Final disease or condition	hemiz 1	ardidme	1 90 atty			Onset and Death	
	/Medical Examiner		resulting in death)	a consequence of):	1	0 /				
		r.	Sequentially list conditions, b.	a consequence of;						
	uted f insit	min	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence ory.						
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XOC .	leath certific attending p	Physician/M	23h Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy	,		23d. Date of deli		
5	the a	/sic	1 ☐ Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	t time of death 5	Other (specify)			Month	Day Year	
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<u> </u>	an: T tificat tor, pa		25. Was case referred to medical			Of Piece of Death	1 ☐ Yes 2	No 1 ☐ Yes	2 🗆 No	
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ב ב	Veryliad or Artending Physician: The law requires that the death certificate be executed yt hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	- 1								
-	Io the hospital or Attending within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical	29a. Certifler Check only one) Certifling Physician: To the best of the basis of and manner state.	examination and/or inv	n occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
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,	> - 0		A PLANT		75	3166	A	ril is	2009	
	,	-	30. Name and address of person who completed cause of di	eath (Item 23a) (Type. F	Print)		1/1/	111	,	
K	SCH		Fire Mariglus, mo 3	169 Braver	tan A	Suite WI .	Edgewate	mD 2	1037	
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	Registra	r	APR 2 0 2009 Sene	a B. A.	ake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** \mathbf{P}^{M} 2009 April 16, 6:50 George Louis Hayhoe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 87 Director <u>577-20-8058</u> Jan. 11, 1922 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyghene.
Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be nonee. 12804 Meadow View Drive 20878 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Film Processing Lab. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Louis Hayhoe Ethel C. Hayhoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan M. Thompson, daughter 4984 Linganore Woods Road, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/23/2009 Brentwood, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service License 23a. P. M. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s fock, or heart failure. List only one caus on each line. 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death Immed ate Cause (Final diseas for condition resulting in death) west **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 2 340 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ueatii? 1∐Yes 2∏ No 1□ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural n 24 hours after death.

he Funeral Director; A
pletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

P.O. Records, Vital ō Division To the Hosp within 24 hou To the Fune completely fi

Maryland

Baltimore,

68760,

15+1

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 2 1 2009

29b. Signature and title of certifier

30. Name and address of person

300 W. 94r 32, Registrar's Signature

who completed cluse of death (Item 23a) (Type, Print)

Street Frederick, MD

29c. License number

D16428

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year STANley HUGAN 400 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Haspital

7. Age (In yrs. last birthday) Columbia HOWARD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 82 Director 119-16-5267 07/05/1926 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evaninar must be notified at once. 1 Yes 2 No Director Middle Village NY Queens 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 11379 Funeral 84-37 Fleet Court Apt. 78A United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. XYes 2 🗆 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1944-46 1 ☐ Yes 2 No Specify: ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Morris Hogan Dora Berman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita L. Baena - daughter 10364 Waverly Woods Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremetory 4-20-2009 Hanover, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYCARDIAL INFARE TION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 Tes To the Hospital or Attending Physician; filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA မ 1 Inpatient 24 hours after death. Funeral Director: After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 t (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053051 Apr 22, 2009 (S) ex 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Athea Howard Co. General 5755 Cedar Lane Columbia, MD 21044 31. Date filed (Month, Day, Year) Begistrar's Signature State APR 22 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/Medic		Cynthia E	1:2abeth	1-70171	W - W		7	12 Caus	ty of Death	G.70 F	
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			32157 Perryhaw	Kin Rd		Prince			<u> </u>	ome		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	/	If Under 1 Year Months Days		(Month, Day,		9. Birthp	place (State or Foreign ntry)	
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	rylar thow	_	10a. State 10b. County	100. 011	y, Town or Loc		N				1 ☐ Yes 2 ☐ No	
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yland	e d la d	Be	/	Villiams			Evelyn	Crawford	-100	20-		
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Ĕ	permit. Pages Department of I Important: If ite any injury or of		*4 □Donation 5 □ Other (Specify)	St.	Mark L	Linesmal	Long 4/1	8/2009 1	rinees	s Anr	W. 21	
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•	1141		30. Name and address of person who co			Print)						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician PM 2009 neen ADYI /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye FEB • 28 , 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Funeral Months Days Hours 1 🗆 M 2 🔀 F 1952 MARYLAND FEB. 213-60-5400 57 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 28a-f show must be notified at 1 ☐ Yes 2X No Director SELBYVILLE DELAWARE SUSSEX 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number ō 31288 INSPIRATION CIRCLE 19975 23a USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. Examiner 1 ☐ Yes If Yes, Give Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛣 No Specify: þ WHITE 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. ADMINISTRATOR LOCAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First. Middle, Last) Be is marked of SLAYSMAN ELIZABETH HERBERT HOLLAND မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31288 INSPIRATION CIRCLE, SELBYVILLE, DE. 19975 EDWARD J. SULLIVAN/HUSBAND Health a Department of Health Important: If item 27 any Injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State ARLINGTON NATIONAL

CEMETERY

22. Name and Address of Facility ARLINGTON, VIRGINA 5/5/09 4 Donation 5 Other (Specify) 21. Signatur HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each in Immediate Cause (Final Leukemic **Physician** undifferentiated disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 🗹 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \square Nursing Home Hospital: 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 npatient 1 Yes မှ 28a. Date of Injury this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Il Director; After to ad in by the funer 1 X Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

after e Funeral I the Hospital

within 2 To the F

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)(0(0(Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 600 North Wolfe St, Baltimore, MD, 21287

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a. Certifier

(check only one)

cos 31. Date filed (Month, Day, Year) 32. Re strar's Signature APR

		For State Registrar		State o	f Marylan	id / Depa		t of H	ealth a		ental Hy		2009	Per men	462	
13:		1. Decedent's Name (/	First, Middle	, Last)		<u>-</u>					2. Date of De Month	ath	Year	3. Time	of Death	
Physicia /Medica	_	Willa:	rd Wil	Lson Higg:	ins						April	26	2009	12:	50 R ^M	
Examine		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					4c. C	ounty of Deatl	1		
		Williamsport Retirement Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				Williamsport If Under 1 Year If Under 24 Hrs. 8.				0. D. I (D)	Washington					
Funeral Director		5. Social Security Num 217-10-263	37	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. 93	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July 22	ıy, Year)	L5 Pole	untry)	e or Foreign ollow,	
land ow		Usual Residence of De 10a. State 10	0b. Counfy		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits	
Mary -f sho fied a	tor	MD Washington Williamsport										1 ∑ Y∈	es 2∐No			
with the a or 28a be noti	Funeral Director	10e. Street and Number 154 N. Artisan St.					10f. Zip Code 21795					_	. Citizen of What Country?			
tems 23	unera	11. Marital Status		Armed Ed	edent Ever in U	.S. 13.	Was Deced If Yes, spec	lent of His	spanic Ori n, Mexicar	gin? (Spe n, Puerto	cify Yes or No Rican, etc.))- 14	Race - Ame Black, White			
ours afte	þ	1 ☐ Never Married 3 ☐ Widowed 4 [Divorced		ve 1 25 / lates 1 0 7 1 9		1 ☐ Yes		Specify:					Thite		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify Elementary/Second	only highes	st grade completed) College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ation fu <i>ring m</i> os)	t of worki	ng		of Business/	,		
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ild be fill lental H ked oth	To Be	17. Father's Name (Fit Harry Hig		Last)				1.7			(First, Middle, e Chane		urname)			
12 shou h and N 7 is mar traumat	F	19a. Informant's Nam Raymond His		nip (Type. Print) Son			ng Address				I Route Numb	-	Town, State, 2		21722	
es 1 and of Health fitem 27 rother tr		20a. Method of Dispos	sition	3 ☐ Removal from	20b. F	Place of Dispo					y 1,		ation - City or		21/22	
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permit. Depart Import any inj		- Kow	ed 1	Bues	ميا		521 S						astle,F			
Distriction		23a. Part1. Enter the shock, or heart f Immediate Cause (Fir	failure. List	only one cause on e	each line.		_				r respiratory a	rrest,			Between nd Death	
Physician /Medical		disease or condition resulting in death)		Due to	PIRATIE (or as a consec	quence of):	M	5mM	AINO	1				2 WE	:EE>	
Examiner	Examiner	Sequentially list condi	itions, ediate	D	15PHAG (or as a consec											
recuted and -transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):						EBRAL #NFARLTS								
ificate be executed g physician and as the burial-transit	cal	G														
rtifical ng phy as th	Nedi	IF FEMALE:														
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent p in the past 12 m 1 Yes 2 1	onths?	1 ☐ Live	tcome pf pregn birth 2 □ Feta nant at time of a nown	al death 3[⊒Ectopic p ⊒ Other (sµ				-	23	d. Date of del Month	ivery Day	Year	
res that the de signed by the a be detached t	by Ph	Part II. Other significa	ant condition	ons contributing to d	leath but not res	sulting in the u	ınderlying o	ause give	en in Part I	l.			e contribute to			
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hysician: The law r his certificate has be I director, page 2 sh	Completed										24a. Was auto perfo 1 Yes		death?	utopsy findin completion c	gs available of cause of	
ctor,	Be	25. Was case referred examiner?	d to medical							e of Death	(Check only					
hysio	Lo L	1 ☐ Yes 2 No	0		Inpatient 2			3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify)								
tending Preath. tor: After the funeral	tion:	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pendin		of Injury oth, Day Year)	28b. Time of Injury	M 2	28c. Injury Work 1 □ `	yat ∢? Yes 2□		28d. Describe	how injury	occurred			
al or Atten after deat I Director d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)								ural Route N	lumber,					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C			ng Physician: To th Examiner: On the i and mar											se(s)	
To th within	M	29b. Signature and tit	lle of certifie	e.MD			²⁹		700)			signed (Mont			
		30. Name and addres			se of death (Iter			7.			MSPOR					
Sta	te	31. Date filed (Month,	, Day, Year)	32. I	gistrar's Sign		0	- (.	0010	-CI M		• [] []	**			
Registra	77	M	AY O	5 2009 1	neva	B. A	Barke	D								

1 - For State Registrar

Be Completed by Funeral Director

2

Examiner

Be Completed by Physician/Medical

Medical Certification: To

/Medical Examiner

State Registrar	State of Mary	•		cate of L		,	Reg. No	2000	9 1446
. Decedent's Name (First, Middle, Last)						2. Date of De	ath Da	y Year	3. Time of Death
		lorsman		01. T.	Landin of David	April			12:55
a. Facility Name (If not institution, give s ALISBURY NURSING 8	REHABILI1		CENTE	R S	Location of Deatl			. County of De	:co
Social Security Number 216–18–8834 6. Sex	M 2□ F 87	In yrs. last birt		Inder 1 Year onths Days	Hours Min.	8. Date of Bir (Month, Di 03/10/	192	2 9. B	irthplace <i>(Stat</i> e or Foreig Country) laryland
sual Residence of Decedent Da. State 10b. County	110	Oc. City, Town	or Location						10d. Inside City Limits
Maryland Wicomic		Fruitl							1 XYes 2 No
De. Street and Number 105D Crockett Av	ve.		10	f. Zip Code 2182	26		10g. Ci	tizen of What C	Country?
1. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was D	Decedent of Hi	spanic Origin? (S	pecify Yes or No o Rican, etc.)	p-	14. Race - An Black, Wh	nerican Indian,
1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: Na	ıvy		es 2 🔀 No	Specify:	,			hite
15. Decedent's Educ (Specify only highest grade	cation e completed)	16a.	(Give kind o	Usual Occupa	urina most of wor	king	16b. K	ind of Busines	ss/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO No	or use retired, foreman		Ü	AT	& Т	
7. Father's Name (First, Middle, Last)					18. Mother's Nan		, Maider	Surname)	
Perry Horsman						Murray			
9a. Informant's Name/Relationship (Ty) William Horsman/br					nd Number or Ru Bale Dr.				, Zip Code)
0a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	I	20b. Place of cemeter	Disposition y, crematory	(Name of or other place	, , ,	Date	20c. L	ocation - City o	or Town, State
4 ☐ Donation 5 ☐ Other (Specify)		Salisb		remato	- '	•		alisbur	
1. Signature of Funeral Service License Routh CL	Rusey (KSP	Hota	lowaydrf Snow H	uheral F ill Rd.	lome Pro	fess	sional A MD 2180	Association 04
20 Port 1 Enter the disease or compli						Daire	uLy,		~ -
23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that coused the ne cause on sach line	e death. Do n	ot enter the				-	· 	Approximate Interval Between
shock, or heart failure. List only on mmediate Cause (Final lisease or condition	cations that crused the	death. Do n	ot enter the				-		Approximate
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State

09-03311	
Elizabeth Harris	

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State of Maryland / Department of Health and Mental Hygiene

		5	1- For State Registrar	e or ivial yland /		tificate of		na mon		eg. No.	201	19 1446
Phys	icia	in/	 Decedent's Name (First, Middle,L 						2. Date of Dea Month April 24, 2		Year	3. Time of Death 2330 hrs
Medical Exa	amu	ner	Elizabeth 4a. Facility Name (if not institution, g	A. Har	ris	Ta	b. City, Town,	or Location o			. County of Death	2330 1115
			Peninsula Regional Med				Salisbury				Vicomico	
Fune				Sex 7. Age	e (In yrs. la	st birthday)	If Under 1 Ye			rth (MM/I	DD/YYYY) 9. Birti Foreigr	
Direct	tor			M 2 X F	44	Yrs.	Months Da	ays Hours	Min. 08/29	/196	54 Cou	/Yrginia
Aug		ŀ	Usual Residence of Decedent 10a. State									10d. Inside City Limits
		-	Maryland Wicomi	ico	Sal	isbury						1 Yes 2 X No
Maryland 28a-f show	dator	Director	10e. Street and Number				10f. Zip Code		1	-	zen of What Coun	try?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she	notified at once.		30100 Provider					804			JSA	
ath wi	st be	Funeral	11. Marital Status1 Never Married 2 X Marrie	12. Was Decedent Armed Forces?					in? (Specify Yes or No Puerto Rican, etc.))-	14. Race - Americ White, etc.	an Indian, Black,
ifter de	ner m	by Fu	3 Widowed 4 Divorc	ed If Yes, Give Year	X No	1	Yes 2 X	lo specify:		-	Specify:	white
hours a	Exami		15. Decedent's Education (Specify				's Usual Occup st of working li		ind of work done	16b. F	(ind of Business/Ir	ndustry
36 hin 72 e.	dical	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		intant		,	ac	ccounting	4
215-0036 be filed within 7 ntal Hygiene. rked other than	he Me	S	17. Father's Name (First, Middle, La			40000	arcaire	18.Mother's	s Name (First, Middle,			3
1214 I be fil ental F	vent,	a	Thomas O'Hara	*			11 0-0-		istina Sch	100		
MD 21 nd 2 should lalth and Mei	natic	유	19a. Informant's Name/Relationship John Harris/spc			No.	-		ber or Rural Route Nul Dr., Sali		-	
e, M l and 2 Health	tranı	ł	20a. Method of Disposition			lace of Disposi	tion (Name of		Date		Location - City or	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural	other		Burial 2 X Cremation 3 4 Donation 5 Other Specia		sa Sa I	rematory or oth Lisbury	Cremat	ory	4/29/09	S	alisbury	, MD
alti rmit. I rpartm rporta	ury 0	ı	21. Signature of Funeral Service Lic		- //	22. H	or 100	ss et Facility	cal Home Pi	cofe	ssional	Association 804
		- 1	23a. Part I. Enter the disease, or cor	Dan	10000	5	01 Snov	7 Hill	Rd., Salis	sbur	y, MD 21	804 Approximate Interval
Physici /Medic			failure. List only one cause on	each line.							ock, or riedit	Between Onset and Death
xamin	ner		Immediate Cause (Final disease or condition resulting in death)	a. Cardiac A Due to (or as a conse			e to m	yocard	Tal Fibros	IS		
		_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
		Examiner	cause. Enter Underlying Cause	C.								
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Box 687 e death certific the attending r	use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	time of dea	ath _	al death (Specify)	B Ectopic	pregnancy		Month D	ay Year
Box e death the attr	detached for use as t	Physician/	1 Yes 2 No 9 V Unknow	wn g Unknown		o ou	lei (Opcolly)					
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tal Reco cian: The law certificate has	or, pag		25. Was case referred to medical	T			26.Pla	ice of Death (1 Yes Check only one)	2 N	lo 1 🗸 Ye	s 2 No
Vita nysicia this cer	direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient		Other4	Nursing Home 5	Reside	ence 6 Other	:
of Vi ing Physi After this	funeral	Ä	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inju (Month, Day,Y	ry ear)	28b. Time of Ir		njury at Work		how inj	ury occurred	
Sior Attend r death ector:	by the	catic	2 Accident 5 Pending Investig.		iun. At ho	mo form stree		Yes 2		Stroot	and Number of Ru	ral Route Number, City
Divi	led in	ertification:	3 Suicide 6 Could no determine	ot be	july - At 110	ine, iaim, stree	t, ractory, onto	e building, et	or Town,		and Number of Ru	rai Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I	completely filled in by the	O F	29a. Certifier 1 Certifying Phys	ician: To the best of m								
To the within To the	comply	Medical		ner:On the basis of examend manner stated.	mination an	nd/or investigati			curred at the time, date			
		2	29b. Signature and title of certifier	V.				nse number	OCME		Date signed (Moi il 25, 2009	nt⊓, Day, Year)
Cul		-	30. Name and address of person wh	o completed calude of d	eath (Item	23a)				1		
C			Theodore M. King, Jr., M		,	,	111 Penn 9	Street, Bal	timore, MD 2120	1		
Red	Sta gist		31. Date filed (Month, Day, Year)	2009 32. Registra	r's Signatur	D. pa	Na					

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

ms 23a or 28a-f show must be notified at

7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b

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Physician/Medical Examiner

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Certification:

page 2 s

this funeral IE FEMALE

examiner?

29a. Certifier

Sunitha Bhoo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WIIVA

State Registrar

9 for Georgia Annu # 1-17 silverspring mD20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Sidney Krauser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Director 049-24-9653 **Poland** October 17, 1915 93 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 U.S.A. Completed by Funeral 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Shamus Synagogue 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moshe Shaiuk Feiga Krauser ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 g Department of Health ar Important: If item 27 Is any injury or other trau Florence Meyer - Daughter 4212 48th Place, NW, Washington, D.C. 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 04/20/2009 Judean Memorial Gardens Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ONGESTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EFFUSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown MELLITUS DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **2**(10 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2500 Other: Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural

Accident 5 Pending investigation Injury within 24 hours after deau..

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MONTROSE ROAD 6121

29c. License number

D57284

ROCKVILLE MD 20852

APR 20

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death Day **Physician** 18, 2009 1:15 Stanley S. Lowenthal April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Casey House Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5/11/1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours New York 1 ☐ M 2 ☐ F 89 Director 138-05-4151 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Exar in strinist be notified at Potomac 1 ☐ Yes 2X No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20854 United States 11215 Seven Locks Road 'natural", or items 23a Pages 1 and 2 should be filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give WWII Year or Dates: 1 □Yes 2 ▼No Specify: ģ Specify: White 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1-4 than Elementary/Secondary (0-12) Health and Mental Hygiene. Owner/ Lowenthal Electric Electrical Supply Co. 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Leber Lewis Lowenthal 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Beryl Lowenthal Feinberg -Daughter 1200 Halesworth Drive Potomac, Maryland 20854 permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any Injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 4/21/2009 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service License 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter directlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Type II Diabetes Mellitus 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Prostate Cancer 2 XNo 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSpice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Patient fell Injury 1 Natural 5 ☐ Pending investigation April 8, 2009 5:00 P within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 X Accident and hit his head 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Daughter's Home 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 1200 Hallesworth Dr. Potomac, MD Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15+1 Decelyne Kouoltchou, m) Dec 63747 April 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

2009

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🖰 🖯 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elaine B. Lessenco 2009 9:25 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10731 Gloxinia Drive Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 21, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2√□F Mary Tand 007-30-6266 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified at Rockville Maryland Montgomery 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10731 Gloxinia Drive 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married White 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) 5+ Elementary/Secondary (0-12) School System Placement Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Paul Samuel Beitler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 10731 Gloxinia Drive Rockville, Maryland 20852 Gilbert B. Lessenco -Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Metropolitan Crematory 4/20/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pancreas Cancer chronic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Work? 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, After t Hospital or Attending ospital c. 24 hours after deau.. ~val Director: Aftr hv the ft/ 24 hours a the To the within ? 10

this

law requires that the death certificate be executed

Box 68760.

P.O.

72 hours after death with

Saltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year, 21 APR

29b. Signature and title of certifi



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D53177

29d. Date signed (Month, Day, Year)

April 20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 15, Day 2009 Year **Physician** 11:00A M Marion Leech /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chevy Chase Montgomery 11 Primrose Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/13/1906 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number 217–28–1878 Funeral Days Hours Min. 1 □ M 2 🗷 F Wash., D.C. 102 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 √ No Director Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 United States 11 Primrose Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2½ No If Yes, Give Year or Dates: 1 □Yes 2 No Specify. Š Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abner Young Leech, Jr. ည Clara Stowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4910 Massachusetts Ave. N.W. #215, Wash., D.C. Paul Cromelin - Executor item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-21-2009 Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 22. Name and Address of Facility

Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia days /Medical Due to (or as a consequence of): Examiner Failure to Thrive 3 years Sequentially list conditions, if any, lacing to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2√□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

Division of Vital Records,

Baltimore, Maryland 21215-0036

P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Dr. Richard D. Schubert

DHMH 17 Rev 1/2001

State Registrar

W

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

11441DC

3301 New Mexico Ave. N.W. #348, Washington, D.C.

29d. Date signed (Month, Day, Year)

20016

4-16-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19, 6:30 P M Winifred Μ. Lembeck 2009 Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2√□ F 218-03-4578 89 Director Tan. 15, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, its Modical Examinar must be notified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 21702 1900 Rosemont Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No <u>ک</u> Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home t of Health and Mental Hy Titem 27 is marked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mame Crosby Graham Rodemeyer ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7101 Ridge Crest Drive, Frederick, MD 21702 Steve Lembeck / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Pages 1 Department of P Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or 4 Donation 5 Dother (Specify) Stauffer Crematory: 4/21/2009 Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demention **Physician** (or as a consequence of): Helli ly MENTHS /Medical Examiner MON THS Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Éctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe certificate 2 No 1 □ Yes 2 Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

15

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

PRAYEEN BOCANO MIMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

196TT DELVE, PREDERICK NO - 21702. 32. Registrar's Signature

00062223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7: 45 PM Month **Physician** APRIL Barbara M. Lawton 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F 492-32-7245 78 June 6, 1930 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show notified at 1 XYes 2 □ No Director MD Prince George's Bowie 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or Examiner must be 20715 USA 3803 Woodhaven Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? natural", or items 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Law Office Secretary 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental. Important: If Item 27 is marked any Injury or come. Roy Maule Margaret Sterret ပ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Lawton / daughter 3803 Woodhaven Lane Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/17/2009 Bayview Crematory 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee Bowie, MD 20715 6512 NW Crain Hwy. 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCIEROTIC VASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown MENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No OBSTRUCTURE PULMONARY 24a. Was an autopsy performed? Yes 25 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D57531 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Veterans Hay, Suite 204 millosville, mg 21109

Registrar

State

DHMH 17 Rev 1/2001

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32. Registrar's Signature

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31. Date filed (Month

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Please Type or Print in Black Indelible Ink, Ensure 41 Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ARVIN MANEY 14, 2009 APRIL 4:22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. | 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**□ M 2□ F Days 50 Director 432-21-3916 1/09/1958 Arkansas Usual Residence of Decedent Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified a once. Director 1√Yes 2□No Jefferson Charles Town W۷ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 25414 161 Burnlea Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑1Yes 2 □ No If Yes, Give Year or Dates: 1977 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 9 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Szramski Floors Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Turner ပ Benjamin Maney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Burnlea Road, Charles Town, WV 25414 Jacqueline Maney/wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Smithsburg Crematory 4/20/09 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Jefferson Chapel Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eremi **Physician** bac D disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dremmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Examiner Due to (or as consequence of): The law requires that the death certificate be executed sician and burial-trans Neutropenia Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an autopsy performed? 1 □ Yes 2,4 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mvung Hee Nam, 400 W 7th Street, Frederick MD 20701 Myung Hee Nam, 31. Date filed (Month, Day, Year) 32. Registra 's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, ^{Day} 2009 **Physician** 3:10A Makowelski, Sr Alexander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Civista Medical Center LaPlata 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov. 30, **Funeral** Year) Min. Months Days Hours 1**√**2 M 2 □ F 579-48-1232 1931 Director Poland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XINo Director Maryland Charles Marbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 4155 Chicamuxen Road 20658 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 2 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nikolai Makowelski Ludmila Schwandt ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tra once. Daughter Catherine Gray 4155 Chicamuxen Rd., Marbury, Md. 20658 20b. Place of Disposition (Name of cemetery, crematory or other place) April 18, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chicamuxen, Maryland Chicamuxen United Methodist Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause Final

APT SOLVER OVEC CARNES ASSOCIATED Approximate Interval Betweer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

Registrar's Signature

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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· *		Anne Arundel Medical Center Annapolis Anne Arund 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth										
Funeral Director		5. Social Security Number 023-18-7789 6. Sex 1 M 2 F 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 87 Yrs. 80 Date of Birth (Month, Day, Year) 4/25/1921 9. Birthplace (State Country) Min. 4/25/1921										
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Jing F	ion:	27. Manner of Dea 1 Natural	ath 5	28a. Date of Inj (Month, Da	ury a <i>y, Year)</i>	28b. Time of Injury	Wor	rk? ⊡Yes 2 □No	28d. Describe ho	ow injury occurred		
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only		Physician: To the best								
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		30 Name and add	iress of person w	no completed ause of	death (Iten	n 23a) (Type,	Print)	00-1	1 /	1	10001	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** P^{M} April 5 2009 3:50 Carroll Matthews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady 1246 Scott Town Rd. Side Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 25 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Maryland 219-30-1272 74 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Marical Erandon and the notified at 1 ☐ Yes 2 🙀 No Directo Shady Side Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1246 Scott Town Rd. 20764 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Completed by Specify Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the than any Injury or other traumatic event, the than application. College (1-4or 5+) Elementary/Secondary (0-12) 11th0 Marine Construction John Crandel & Sons 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Norman Matthews Louise Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Thompson(Daughter) 5904 Shady Side Rd. Shady Side, Md. 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-20-09 Shady Side, Md. 4 ☐ Donation 5 ☐ Other (Specify) Scott Cemetery Miniame Records of Scill Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Ente, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Try, localing to minimal characters. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform certificate 1 □Yes 2 No 2 □ No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 7 No Other: 4 \(\subseteq \text{ Nursing Home} \) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 ☐Other (Specify) Certification: To this 27. Manner of Leath 1 [7] Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check one and manner stated. 29d. Date signed (Month, Day, Year)

State Registra

31. Date filed (Month, Day, Year)

and the of certific

29b. Signature

30. Name and addre



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Robert L. Muir, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Doctors Community Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Vear Days Min. 1**⊠** M 2□ F Months Hours 579-36-0458 12-13-1929 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Prince George's Glenn Dale 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 10009 Worrell Avenue 20769 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □Yes 2X No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Bricklayer</u> 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Muir Lillian McGrath 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce K. Muir/Spouse 20a. Method of Disposition 10009 Worrell Avenue Glenn Dale, MD 20769 20b. Place of Disposition (Name of All Salings Monle) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-2009 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne, MD Cemetery 22. Name and Address of FacilityBeall Funeral Home 21. Signature of Funeral Service 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death racomtopodo Immediate Cause (Final Lesto a. disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Ves 2 2 No wie C 1 ☐ Yes 25. Was ça 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Examiner must be notified at agnee.

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Certification: To

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

1 Natural

3 Suicide

2 Accident

4 Homicide

er)	io	medical	
S	2 100			
rof	Death			

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐Yes 2 ☐ No

29a. Certifier (Check only one)

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier m.1 29c. License number C

29d. Date signed (Month, Day, Year) 17/2003

ota

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 tot Executive Pl. 2002 AL MA ware)

State Registrar

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Wedical Examin		John David Mit 4a. Facility Name (if not institution, give		mhor)		4b. City, Town, or	Location of D		10, 20		unty of Death	
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Funeral	-	5. Social Security Number 6. S	ex	7. Age (In yrs.	last birthday)	If Under 1 Yea	ar If Under 24	4Hrs. 8. D	ate of Birth	(MM/DD/Y	YYY) g. Birt	hplace (State or
Director						Months Day		Min	4/03/	,		New Jersey
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5-0 led w Hygic othe		17. Father's Name (First, Middle, Las	t)				18.Mother's N	Name (First	, Middle, M	aiden Surr	name)	
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D 2,	유[19a. Informant's Name/Relationship (1		ng Address (Stre						, Zip Code)
ME and 2 saum:		Charles E. Mitch	nell / l	prother		Peck Rd.		ningto			9335 ation - City or	Town State
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Page Page ment tant:		4 Donation 5 Other Specifi		Ba		crematory		/18/2			imore,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee //			. Name and Addres					Home	
	_	23a. Pert I. Enter the disease, or com	dole_	and the deat	b Do not onto	512 NW C	rain H	Wy.	BOW1	e, MD	20715	Approximate Interval
Physician /Medical		failure. List only one cause on e	ach line.				, 30011 a3 card	100 01 1030	iratory arro	ot, orlook,	SI TIOUIT	Between Onset and Death
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Box 68760, s death certificate be the attending physicied for use as the buri	Ž	23b. Was decedent pregnant in the past 12 months?	1 Live			Fetal death 3	Ectopic p	regnancy		Mo		Day Year
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Reco	Completed							1	✓ Yes 2		death? 1 ✔ Y	es 2 No
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed at Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	Bec	25. Was case referred to medical				26 Plac	ce of Death (C	heck only o	one)			
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ion trendicath tor:	Certification:	1 ✓ Natural 5 Pending 2 Accident Investiga	tion			1	Yes 2 N					
Divisior Hospital or Attend 24 hours after death Funeral Directors	iffic	3 Suicide 6 Could no	t be 28e. Pla	ce of Injury - At	home, farm, s	reet, factory, office	building, etc.		Location (Sor Town, Si		Number or Ru	ural Route Number, City
Divi	E E	4 Homicide determin	ed (Specify									
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To th Withir To th	Medical		and manner	of examination stated.	and/or investi			ired at the	une, date a			
	Σ	29b. Signature and title of certifier					nse number	OCME			-	onth, Day, Year)
		1/ John Ill.	Kind	JR., M	- D.		:.M.E.			April 1	7, 2009	
(C. L. LT)		30. Name and address of person who		se of death (Ite	,	444.0		mo== 14	D 04004			
(7×10)		Theodore M. King, Jr., M		ant Medical		111 Penn S	ireet, Balti	inore, M	D 21201			
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DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2009 18 April Judy Ann Martens 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Myersville 10826 Easterday Road Frederick 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Year) 1 □ M 2 🛣 F Director 219-46-8950 62 17, 1946 Maryland Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, Ite Mandel Estaminer must be notified at any or other traumatic event, Ite Mandel Estaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Frederick Myersville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 10826 Easterday Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ∐Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Contractor Owner / Operator 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Earl Sutphin Lois Marie Umbarger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Poole, husband 10826 Easterday Road, Myersville, Maryland 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/2009 5 ☐ Other (Specify) Germantown Baptist Cemetery Germantown, Maryland 21. Signatur 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 0 23a. Part 1 Em + the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or part failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Squite (Final Physician disease or condition resulting in death) Lung Cancer 18 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or it jury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I ined by the a e detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ certificate has been sign frector, page 2 should be 1 A Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes al or Attending Physician: 's after death.'
Al Director: After this certifica of in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) April 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th Street Frederick, ND2170 15 5 Rande MI namy 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 1 2009 Registrar W. serve

1-	For State Registrar
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			1 - State Registrar		Ce	rtificate of L	Death		Reg. No.			
			1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death		
	Physici /Medic		JOHN W. MI	TCHELL				Month APPL	Day	Year 2009	22:18 PM	
1	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat		4c.	County of Deat		
and a			JOHNS HOPKINS BAY	VIEW MEDICAL	CENTER	BALT	TIMOR	E		N/A		
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th ay, Year)	9. Birt	thplace (State or Foreign	
	Director		213-20-3300	83	Yrs.			2/18,	/1926	Mar	ryland	
	pu >		Usual Residence of Decedent 10a. State 10b. County	100 08	y, Town or Lo	antion					10d. Inside City Limits	
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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Michell Exa., increment the inclified at	Funeral Director	5000 SE Crain Hwy		- 140	207				USA		
	er de	un.	11. Wantai Glatas	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	specify Yes or No to Rican, etc.))-	 Race - Ame Black, White 		
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a	ild be fenta rked ic ev	To B	J.Harold Mitchell				Mar	cion Wall	ker			
Maryland	shou and N s mai	-	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailir	ng Address (Street a	and Number or R	ural Route Numb	er, City o	r Town, State, 2	Zip Code) 20773	
Ž	nd 2 alth a 27 is		Evalina S. Mitche	ll/Spouse							rlboro, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evan, insertment by nuffiled at once.		20a. Method of Disposition	20b. F		sition (Name of matory or other place		Date		cation - City or		
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ord	w requires to be a signary should be a	ted				-		1 🗆	Yes 2[≝No 3∐ Pr	robably 4 🗍 Unknown	
ပ္ပိ	e law r has be re 2 sh	ed l						24a. Was		24b. Were au	utopsy findings available completion of cause of	
<u> </u>	: The	Completed						perfo 1 □ Yes	ormed?	death?	2 □ No	
<u>=</u>	slcian: The certificate I rector, page	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only				
<u></u>	hysle his c		1 Yes 2 No H	ospital: 1 Inpatient 2			4 🗆 Nursing i	lome 5 ☐ Resi	idence (6 □Other (Spe	cify)	
Division of Vital Records,	ng P	Certification: To	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	y at ?	28d. Describe	how injur	y occurred		
Sio	tendi eath. or: A	cati	2 ☐ Accident investigation				Yes 2 □ No					
Ž	or At Iter d iirect n by	ŧ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str <i>y)</i>	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number or Ru)	ural Route Number,	
	urs a urs a eral C		20 0 177	40								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director; to	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Phys 2 ☐ Medical Examin	sician: To the best of my knowner: On the basis of examina	wledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	e cause(s) , date and) and manner as d place, and due	s stated. e to the cause(s)	
	the the	Med	29b. Signature and title of certifier	and manner stated.		29c. License	numher		20d Dat	te signed (Mont	th Day Voorl	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LOIS ANN MATSON APRIL 16, 2009 4:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 58 Yrs. Hours Min. 1 □ M 2 🗶 F NEW YORK DEC. 10, 1950 Director 085-42-2691 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show 1 Tyes 2 XNo Directo MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 100 QUEEN COLONY HIGH ROAD 21666 UNITED STATES Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🕱 No If Yes Give Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) STORE MANAGER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 Is marked o မ LEONARD MAARTENS PEARL SMITH traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS MATSON/HUSBAND 100 QUEEN COLONY HIGH ROAD, STEVENSVILLE, MD 21666 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIL 17. permit. Pages 1 Department of H Important: If ite any injury or ot CHESAPEARE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CENTER 2009 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A., 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Part 1. Enter the discase, or complications that caused the shock, or heart failure. List only one cause on each line. t codsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1, En Immediate Cause (Final disease or condition resulting in death) **Physician** いりてして BRAIN 6 W/C /Medical Due to (or as a consequence of) Examiner RREST MR DIAC 6 WC Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed lan burial-tra Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. physician the burial Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□Yes 2☑No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOWENS BANKIN / IN 1∐Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this HOSTICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury HUU SÉ 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

State Registrar

Medical

29a. Certifie

(Check only

29b. Signature and title of cartifie

ise of death (Item 23a) (Type, Print)

DEFENSE Haltwa

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1/ Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Brint in Black Indelibles by K. Frishing All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:30 AM MITCHELL April 28, PHYLLIS TALBOTT 2009 Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F Maryland 217-26-1854 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified in 1 □Yes 2X No Funeral Director Forest Hill MD. Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 109D Sunshine Court 21050 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. Specify: Completed by 3 Widowed 4 □ Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugene Be Bevan Cavalier Talbott Nellie Ira ၀ 19a. Informant's Name/Relationship (Type. Print) Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 in-law Paula R. Reynolds 2500 Waterside Drive <u>Unit 104</u> Frederick Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition In portant: If it ary injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 4/30/2009 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E.G. Kurtz & Son Funeral 21. Signature of Funeral Service Licensee Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Onset and Death Immediate Cause (Final **Physician** olymicrobia disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Multiple Sc Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of): ハナイル4)(Phyllis M80030650 Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 🗆 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? 1 □ Yes 2 No page 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred he Hospital or Attending P n 24 hours after death.
he Funeral Director; After t pletely filled in by the funera Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. To the Newithin 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 130068014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr. Bel Air, m 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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		ل	1- For State Registrar		Certifica	ate of Death			Reg. No.	
Med	Physicia fical Exami		Decedent's Name (First, Middle,La COURTNE	•	NT T	CETV		2. Date of Dea Month April 25, 2		3. Time of Death 1120 hrs
	TOUT EXAMIN		4a. Facility Name (if not institution, gi		1/1	CELY 4b. City, Town	, or Location of		4c. County of Dea	ath
			Holy Cross Hospital			Silver Sp	ring		Montgomery	,
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birth					Birthplace (State or Foreign Country)
	Director		217-83-9930 1	M 2 XF		Yrs. Months 2	Days Hours	Min. Jan.		Maryland_
	y.	ļ	Usual Residence of Decedent 10a. State 10b. County	1100	City, Town	or Logation		_		10d. Inside City Limits
	&		MD Montg				~			1 XYes 2 No
	rylanc ia-f sh	햠	10e. Street and Number	omery	PITA	er Sprin		T	10g. Citizen of What Co	ountry?
	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	4502 Sigsbe	e Road			209	06	U.S.A	
	with t ns 23a		11. Marital Status	12. Was Decedent Ever	in U.S.		gin? (Specify Yes or N	o- 14. Race - Am	erican Indian, Black,	
	death or iten	Funeral	1 X Never Married 2 Marrie	Armed Forces?	10	If Yes, specify Cu	ıban, M exican,	, Puerto Rican, etc.)	White, etc	Black
	after	3		ed If Yes, Give Year or Dates:		1 Yes 2 X			эреспу.	
	hours frantu	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade complete College (1-4 or 5+)		Decedent's Usual Occi Juring most of working			16b. Kind of Busines	s/industry
	hin 72 e. than	Completed	N/A	College (1-4 of 5+)		N/A			N/A	
	21215-0036 yald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	5	17. Father's Name (First, Middle, Las	et)			18.Mother	's Name (First, Middle,		
	21; be fill ental F	Be	Leon Smith					eena Nice		
	Should and Me	리	19a. Informant's Name/Relationship						umber, City or Town, St	
	Baltimore, MD oermit. Pages 1 and 2 she Department of Health and Important: If item 27 is njury or other traumati	1	Sheena Nicely 20a. Method of Disposition			502 Sigs of Disposition (Name o		d Silver Date	Spring,	
	Ore ges 1 a t of H		1 X Burial 2 Cremation 3	Removal from State	cremate	ory or other place)				·
	it. Par	-	4 Donation 5 Other Special 1. Anature of Funer Hervice Lice		Gate	of Heav	en	5/1/09	Silver	Spring, MD Home, PA
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	Physician	۲	23a. Part I. Enter the disease, or confailure. List only one cause on	plications that caused the d	eath. Do no	t enter the mode of dy	ing, such as c	ardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
	/Medical xaminer			sach line. a. Sudden unex	cplair	ed death	in infa	ncy (SUDI)		Death
	,		or condition resulting in death)	Due to (or as a consequen	ce of):					
		<u>=</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):					+
		Examin	(Disease or injury that initiated	Due to (or as a consequen						
4	d ansit		events resulting in death) Last	d.	ce or):					
	Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	sician/Medical	XUNPENDED		27 , 28a	-f,perME,	g893 7	//20/09 TT		
	760, cate by physic the but	₩.	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of deliv	very
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	ian:	Bec	25. Was case referred to medical examiner?			26.F		(Check only one)		
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	Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate b rs after death. al Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the bu		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		1	Injury at Work	1	e how injury occurred	
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	Divi	Certification:	3 Suicide 6 X Could no determin	ot be	idence		oo ballaliig, el	Silver	State) 4502 Si r SPring, M	Rural Route Number, City gsbee Rd
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		20a Certifier	cian: To the best of my know			e, date and pla			
	Fo the vithin.	Medical		er:On the basis of examinati and manner stated.	on and/or ir	nvestigation, in my opi	nion, death oc	courred at the time, dat	e and place, and due to	the cause(s)
	. > - 0	Σſ	29b. Signature and title of certifier			29c. Lie	ense number		29d. Date signed (Month, Day, Year)

OCME

Registrar

Melissa Brassell, MD 31. Date filed (Month, Day Year) 2009 State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 26, 2009

2. Date of Death Detedent's Name (First Middle Last A Month Physician urner IXON -/Medical 4b. City, 4a. Facility Name (If not institution, give street and number Town, or Location of Death County of Deat **Examiner** MD Burnie tinne)altimore Nashinaton len Pecica Date of Birth (Month, Day, pr 20 5. Social Security Number r 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 1920 1 □ M 2 🔀 F Months Davs Hours 212-16-9534 88 Apr Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10b. County 10a State traumatic event, the the dical Examiner must be notified at Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7745 Hartwell Rd. 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2√☐No Specify Specify: Black 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th n Business Owner Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elijah Hart Beulah Suit ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Alexis C. Davis(Daughter) 813 Northfield Lane Crownsville, Md. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-20-09 Memorial Park Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Montgame Rockes of Eacilisions Mortuary, P.A. 21. Signature of Funeral Service Licenses Larry B. Leese MOC483 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of) Box 68760.

Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 🕅 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death accounted to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Attle of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

P

Carolina

10d. Inside City Limits

1 ☐ Yes 2X No

21032

Approximate Interval Between Onset and Death

days

2009

N.

9. Birthplace Country)

P.O.

Records,

Division of Vital

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After

death.

after death Director:

e Funeral

within 2

State Registrar 1 - For State Registrar

IF FEMALE

30. Name and address of person

ladim 31. Date filed (Month)

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

32.

RICKY APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y JULY 15 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 □ F 53 578-74-0346 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, Ir. Murica Ermmiss bonotified at uny or other traumatic event, Ir. Murica Ermmiss bonotified at 10c. City. Town or Location NEW CARROLLTON PRINCE GEORGE'S Director MD 10f. Zip Code 10e. Street and Number 20784 6008 MENTANA STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NEAL RUTH MCCAIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6008 MENTANA STREET NEW CARROLLTON, MARYLAND 20784 F. NEAL/Wife Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other a permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 4/23/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furieral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNG CANCER WITH METASTASIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

NEAL

K.

Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

2. Date of Death

3. Time of Death

9. Birthplace (State or Foreign

WASHINGTON, DC

10d. Inside City Limits

1 TyYes 2 ☐ No

8:35 A M

2009

PRINCE GEORGE'S

14. Race - American Indian Black White et-

Specify: BLACK

16b. Kind of Business/Industry

20c. Location - City or Town, State

CLINTON, MARYLAND

PRIVATE

4c. County of Death

10g. Citizen of What Country?

Examiner or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

To the Hospital

Physician

burial-tran

Physician/Medical

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Completed

Be

Certification: To

Medical

tending physician a r use as the burial s been signed by the should be detached death neral Director: , filled in by the f within 24 hours a

To the Funeral C

completely filled

	SEPSIS	5
RENAL FAILURE	RENAL	FAILURE

23b. Was decedent pregnant

1 ☐Yes 2 ☐No

9 Unknown

in the past 12 months?

resulting in death) Last

IF FEMALE:

1. Decedent's Name (First, Middle, Last)

RESPIRATORY FAILURE

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and title of certification

Hospital:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 X Inpatient 28a. Date of Injury (Month, Day, Year)

> 29c. License number D 16273

Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

performed? yes 2 🖾 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🛛 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REVATHY MURTHY MD 6130 LANDOVER ROAD LANDOVER, MARYLAND 20785

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

31. Date filed (Month, Day, Year) State Registrar



DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARIE EDNA NORRIS /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Age (In yrs. last birthday 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace **Funeral** Months Days Hours 1□M 257F 218-32-9378 94 Director North Carolina April 15,1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b Counts 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Harford Darlington 1 ☐ Yes 2X No MD Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4041 Conowingo Road, Lot #47 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced "natural", Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natur ury or other traumatIc event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Reeves Laura Rector 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerlene Atkins/Daughter 4041 Conowingo Road, Lot #47, Darlington, MD 21034 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem Gardens 5/4/2009 Bel Air, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Lice 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lyman /Medical Due to (or as a consequence of): Examiner upurmsim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a co sequence of) Due to (or as a consequence of): physician ar s the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9☐Unknowr 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Rnown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page ; performed 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[VNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAY 05 Registrar

DHMH 17 Rev 1/2001

217

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev **Physician** 2:30 Pm Anthony April 09 20 andrea /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4622 Green Ridge Court Huntingtown Calvert If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1XIM 2□ F 577-62-8698 61 Yrs. Director 6, Pennsylvania Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar maint be notified at 1 ☐ Yes 2 No MD Funeral Director Calvert Huntingtown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with 4622 Green Ridge Court 20639 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status l Tyes 2 □ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ۇ م 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's College (1-4or 5+) Elementery/Secondary (0-12) Police Officer County Police 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Peges 1 and 2 should be 1 nent of Health end Mental I Int: If item 27 is marked o Joseph Prestandrea. Leona Castanzo 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health end: If item 27 is r Susan Prestandrea (wife) 4622 Green Ridge Court Huntingtown, MD 20639 other 1 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Apr 28 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5 Clinton, MD Lee Crematory 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J Coff Owings, MD 8125 Southern Maryland Blvd. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **P**hysician Immediate Cause (Final disease or condition resulting in deeth) /Medical Pancreatic Examiner Due to (or as a consequence of) by Physician/Medical Examiner urs efter death.

erai Director: After this certificate has been signed by the attending physicien end filled in by the funeral director, page 2 should be detached for use es the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral C completely filled the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steled.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steled. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of cert

Division of Vital Records, P.O. Box 68760,

State Registrar

YYYON 31. Date filed Wonth, Day, Year) APR 22 2009

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

Merrimac

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 20, 2009 Werner P.B. Plaut 8:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 4835 Cordell Avenue #1115 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Aug 23, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 084-12-9983 85 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is merked other than "natural", or items 23a or 28a-f show Lry or other treumatic event, If a Meulcal Examinar must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4835 Cordell Avenue #1115 20814 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊕ Yes 2 ⊟ No If Yes, Give Year or Dates: 1943–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Inventor/Manufacturer Industrial Conveyors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Plaut Gertrude Haas 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Plaut Christian/daughter 72 Bryant Dr. Livingston, NJ 07039 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important; If Ite eny Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 04/22/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 21. Signature Funeral Service Licenses Goilig Home Cremation Service P.O. Box 784 6 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Lymphocytic Leukemia years disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 □ Yes 2 □XNo certificate 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Director; After 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23308 April 21, 2009 12+1 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) El Victor M. Priego, M.D. 6420 Rockledge Drive Suite 4100 Bethesda, MD 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician EDNA G. RENN 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. Counfy of Death 4b. City. Town, or Location of Death Examiner HAGERS I UVIVIVIII B. Date of Birth (Month, Day, Feb. 3, WASHINGTON JULIA MANOR Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 220-18-0482 92 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment in an tour by nortified at once. 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16114 Spade Road 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. white þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) clothing Elementary/Secondary (0-12) College (1-4or 5+) marked for button holes manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ross Calvin Harbaugh Anna Mae Carpenter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Renn - son 16128 Spade Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Broadfording Cemetery 4/28/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 2060 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DIABETES MELLITI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine EMENTIA physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 1 □Yes 2 No 2**X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 2 Accident funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a completely 10H-6

Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier

333 Mill St.

Kate M.Smith.

Hagerstown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NURSE PRACTICTIONER

CERTIFIED REGISTER D

Medical

R128088

29d. Date signed (Month, Day, Year)

412312009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3. Time of Death Month Dav **Physician** 30 PM onrad 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Sity, Town, or Location of Death **Examiner** A Medica ALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 21, 1945 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. Funeral Days Hours 1**X** M 2□ F NEW YORK 63 Director 093-38-0300 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ∐Yes 2 No Director MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1621 BAYSIDE DRIVE 21619 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. within 72 hours after 1 ☐ Never Married 2 ★ Married Yes 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1965-1969 "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. is marked other than GROUNDSMAN LANDSCAPING 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be far and Mental F ANDREW CONRAD RANGS LENA HEUER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If item 27 is n 1621 BAYSIDE DRIVE, CHESTER, MARYLAND 21619 SANDRA E. RANGS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) APRIL 24 CHELTENHAM TERANS CEMETERY CHELTENHAM, MARYLAND 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CLICKICA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last and certificate be exec Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a Ö 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s has autopsy performe Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After t (Month, Day 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after To the Hospital c within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

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npleted cause of death (Item 23a) (Type, Print)

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32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month April 18. 2009 6:40 Α Samson Reid 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Prince George's Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Davs 1 🕅 M 2 🗆 F 89 245-14-3580 Dec 25. 1919 South Carolina Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10h County 1 Yes 2 No Landover Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 United States 7109 East Forest Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 □ Never Married 2 □ Married Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie B. Roseboro Will Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7109 East Forest Road Landover, MD 20785 Annie M. Daniels - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Tuckers Grove U. Meth Church Cemetery April 25, 2009 Lincolnton, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death + or AZA disease or condition resulting in death) de Kinson, 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):, Due to (or as a consequence of) 5 57 B 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide

Examine be executed burial-trar Box 68760 physician attending physic for use as the b ed by the a detached for o. σ. signed to Division of Vital Records, icate has been signated page 2 should b funeral director, Certification: To I or Attending Patter death.

Director: After 1 After filled in by the

Physician

/Medical

Examiner

Funeral

Director

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ed other than "natural", or items 23a or 28a-f shore event, the Mexical Examiner must be notified at

nd Mental Hygiene. marked other than

traumatic

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permit. Pages 1 and Department of Health Important: If Item 27 any injury or other truonce.

Physician

/Medical Examiner

72 hours after

Saltimore, Maryland 21215-0036

Physician/Medical þ Completed Be

IF FEMALE: 23b. Was decedent pregnant

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number 18PP200U 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mukemil andella Imp

and manner stated.

3001 Hospital Drive Cheverly, MD 20785

State Registrar

Medical

31. Date filed (Month, Day, Year)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital o within 24 hours af To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a Per PHY \$10e Per FH C892 6/02/09 JH State of Maryland / Department of Health and Mental Hygiene | | | | | 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year OR **Physician** ADRI 2009 RIGGS 28 ELIZABETH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name of Inflight Attion, give street and number, 500 Defford Place Examiner MONTGOMER THICOMA Park, Markend M H Under 1 Year H Under 24 Mrs. B. Dafe of Birth Month Days Hours Min. Month Day (Year) 917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ R 214-07-2115 92 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Takoma Park 1 □¥es 2 □ No Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Bell Ford 500 Delford Place 20912 USA death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ★0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0036 white If Yes, Give Year or Dates: þ 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 72 (Specify only highest grade completed) at Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Southland Corp. store clerk permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if item 27 is marked other tt any injury or other traumatic event, Illus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie (Smith) Jones Harry Jones ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 Pavia Court Bowie MD 20720 Informant's Name/Relationship (Type, Print)
Debra Saathoff daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Luke's Cemetery 4/30/2009 MD Cumberland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lio 22. Name Scarpeill' Fulleral Home, PA nsee 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Fine) disease or condition resulting in death) ARTERY DISEASE Pnysician CORONARY /Medical Due to (or as a consequence of): **Examiner** Suppliably list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: esn 23d. Date of delivery 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months2 ξ 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown þ ٥. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 20 MG 3 ☐ Probably 4 ☐ Unknown HYPERTERSION Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an D EMENTIA autopsy performe certificate has page 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 7 Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ို this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident hours after death uneral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20058390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARVIS AVENUE SOITE 200 QUENDALE UD 2013 HITTITUM 5711 SURESHKUMAR 31. Date filed (Month) State Registrar

DHMH 17 Rev 1/2001

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G891,5/14,09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 58 M bICK Apri 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore City Battomore ate 5286 Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/25/1953 7. Age (In yrs. last birthday) 9. Birthplace Country) (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F 44-5284 Director 55 Ravenna, OH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event. If the angle of the same once. 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2X No PA Cumberland Mechanicsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3007 Warren Way 17050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No ģ Specify. Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Autobody Repair Technician Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Brooks Stahl Shirley M. North ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Leidigh Stahl 3007 Warren Way, Mechanicsburg, PA 17050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State Evans Cremation Service 4/24/09 Leola, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. 21. Signature of Funeral Service Licensee M = 00849Part 1. Enter the disease, of complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MURTI-ORGAN **Physician** hours /Medical Due to (or as a consequence of) Examiner hours 5 vone COAGULOPAIN' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit years AUD STACE Due to (or as a consequence of) Box 68760, years Physician/Medical Claryos15 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 X No this certificate ! 1 ☐Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To the Hospina. ...

within 24 hours after death.

To the Funeral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 181 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South treene MD 21201 1ASON MD 22 Baltmore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Spillers Ruth Hart 6:37p M 2009 April 14, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 27, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 13 F Months Days Hours Washington DC 213-12-2784 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mertal Hygiens. Firem 23 a or 28a-f show other traumatic event, the Mexical Extribution is used to under traumatic event, the Mexical Extribution is used to confine a second other traumatic event, the Mexical Extribution is used to confine a second other traumatic event, the Mexical Extribution is used. Washington N/A DC Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 United States 308 Emerson Street NW Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: Colored þ 3 Wildowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DC Public School College (1-4or 5+) Elementary/Secondary (0-12) Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Davenport Thornton J. Hart ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any Injury or other trau Shepherd Street, NE, Washington DC 20017 C. Arnold Hart / brother 1345 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4/23/09 Landover, MD Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Juneral Service Licensee 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA ASPIRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ne Due to (or as a consequence of) Exami sician and burial-tran Due to (or as a consequence of): attending physician for use es the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 5 cate has been si , page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2E ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined or A 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date şigned (Month, Day, Year) 29b. Signature and title of certific ٥ 2000 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

Registrar
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31. Date filed (Month, Day, Year,

Cormon

M.O.

8600 Old Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:25 AM M HENRY HARRISON SIZEMORE. APRIL 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Northampton Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1 ▼ M 2 □ F West Virginia Jan. 21, 1924 224-24-0346 85 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 ☐Yes 2 X No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the IV safest Examinar must be notified Director Frederick Frederick Maryland | 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21704 United States 5761 N. Mayer Drive Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Folces. 1 **X**Yes 2 □ No **1943**-Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 🗷 No If Yes, Give Year or Dates: Specify: 9 Native American 3 Widowed 4 Divorced 1946 Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer State Highway Administration 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison Sizemore, Jeanette Mead Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 5761 N. Mayer Drive, Frederick, MD 21704 Mable M. Sizemore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Boyds Presbyterian 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2009 Church Cemetery Boyds, Maryland 22. Name and Address of Facility Simple Tribute Funeral Service 21. Sign sure of Funeral Service Licen 1040 Rockville Pike, Rockville, Maryland 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Y EARLS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HONTHS Examiner Hemo dialysi Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Vear Month 5 Other (specify) ☐Yes 2☐No ate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 X No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🛭 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1∐Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🖫 Natural ours after death, neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours To the Funeral

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title

Praveen Bolarum,

31. Date filed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

M.D.

certifier



3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO06 L23

29d. Date signed (Month, Day, Year)

April 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20loperFH4/23/09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARLENE SELBIE **Physician** Ε. APRIL 13, 2009 1:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year)

July 10,1937 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 257 F 378-34-2482 Director 71 Michigan Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Montgomery Gaithersburg 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9802 Dairyton Court 20886 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Macy's Dept Store 12th Sales Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event once. Be Herman Meeter Carolyn Landman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Selbie (Husband) 9802 Dairyton Ct, Gaithersburg, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ardent Crematory Hanover, MD 4 □ Donayon 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 21. Signature of Funeral Service L 246 N. Washington St, Rockville, MD 20850 23 Part 1. Enter the dilease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fill ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tailure Kespiratury **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** week Cancer Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed 68760, 1 Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) O 9 Unknown sate has been signed by page 2 should be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Renal taylure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 □Yes 2 No 2 🗆 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation or A. As after dea.

**I Director: A ' by th 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Vital of Selbie, Division within 24 hours a

C

200

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

<u>Vinni Juneja,</u>

21

29c. License number

D0066990

6420 Rockledge Drive, Bethesda, MD 20852

29d. Date signed (Month, Day, Year)

13/09

and manner stated.

M.D.

37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** STEWART DEBORAH APRIL 19 2009 4:36 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MT. RAINIER 3401 BUNKER HILL ROAD Apt C-2 PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F JULY Director 37 12 1971 MARYLAND 214-84-2717 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Modical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE'S MT. RAINIER 1X Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 USA 3041 BUNKER HILL ROAD APT C-2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No Specify: BLACK 2 Specify: 3 ☐ Widowed 4 反 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT PROGRAM SUPPORT ASSIT 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELSIE R. RAYNOR မ MAURICE ELLIOTT STEWART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 139 MOONGLOW ROAD FRUITLAND, MARYLAND ELSIE STEWART/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/2009 DOVER, DELAWARE DIRECT CREMATORY 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROSIS CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) □Yes 2□No 9 Unknown g 🖾 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown OSA OBSTRUCTIVE SLEEP APNEA Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE autopsy POST SURGIAL HYPOTHYROIDISM performed? 2 No 2 No 1X Yes 1∭X Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1X Yes 2 □ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🖎 Natural Injury 5 Pending death. 1 □Yes 2 □ No investigation M Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined n 24 hours after e Funeral Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30930 APRIL 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 VARNUM STREET N.E. WASHINGTON, DC 20017 MAHETEME BAYEM M.D. 32. Registrar's Signature 31. Date filed (Month, Day, State park **IPR 2 2 2009** Registrar

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and it	Examin				ve street and number) ntist Hosp:	ital		4b. City, Town, o	r Location of Death		4c. County		
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Vital	Physician: this certific	Be	25. Was case reference examiner?		Hospital:	ient 2 🗆	EB/Outnatie	ent 3 □ DOA Ot	har:	ath <i>(Check only c</i> Iome 5 ☐ Resi		ther (Speci	
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Certification: To	27. Manner of Dea 1 Abatural 2 Accident		28a. Date of Inj (Month, Da	urv	28b. Time of Injury	of 28c. Inju		28d. Describe			
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	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical C	29a. Certifier (Check only one)	1 XCertifying I 2 Medical Ex	Physician: To the best aminer: On the basis	of examina	wledge, dea	th occurred at the nvestigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature an	d title of certifier	2 11	/		29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
	10		30 Name and ad	dress of nerson wh	o completed cause of	death (Item	n 23a) (Tvpe	D (01238		4/19	1/09	
	EG		Nichola	s J. Far	rell, MD	9901	Medic		r Dr. Roc	kville,	MD 208	50	
	St Regist	tate 31. Date filed (Month, Par Year) 32. Begistrar's Signature fram S. Sauch											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4:30A OU 2009 Stewart Ruby L. 4c. County of Death 4a. Facility Name (If not institution, give street and number) Salisbur Wicomico at H Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 3, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🔀 F 81 1927 213-22-7200 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 U.S. 28269 Riverside Drive Extended 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Johnson Mary Riggin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28272 Riverside Drive Ext. Salisbury, Md. 21 Date | 20c. Location - City or Town, State Raymond Adams/ son 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/21/09 Eden, Maryland Olivet Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hinman Funeral Home MO0295 11673 Somerset Ave., Princess Anne, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specity) 2□N0 (6 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, Ib

Pages 1 and 2 should be f nent of Health and Mental

Physician

/Medical

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be rectified at

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Funeral Director

Completed by

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sician and burial-trans attending physician for use as the buria signed by the a d be detached f has

Examiner

Physician/Medical

Completed by

Be

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Certification;

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should certificate this certific al director, within 24 hours after death

To the Funeral Director;
completely filled in by the

State Registrar

DHMH 17 Rev 1/2001

mue 31. Date filed (Month, Day, Year) APR 22

Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

32. Registrar's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

27. Manner of Death

Natural

2 Accident

3 Suicide

29a, Certifier (Check only one)

29b. Signature

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Spencer Caro1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | December | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year), 1920 Leitersburg, MD 1 □ M 2 📉 F 217-12-1846 Director 88 Usual Residence of Decedent 10c. City. Town or Location 10a State 10d. Inside City Limits 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modeal Examinat must be notified at 1 ☐ Yes 2 No Director Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 14014 Marsh Pike US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Madical Experiment once. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates Specify 2 Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elva Stouffer Lesher L. Oaks ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie K. Cummins 2948 Ashzone Forest Dr. Herndon, VA altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【X Cremation 3 【X Removal from State May 3, 2009 Cumberland Valley Crem. Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. James B. Docuerray 50 S. Broad ST. Waynesboro, PA 23a. Pak 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Probabe Ph Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Probabe sician and burial-trans Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Can should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 0-2 No Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

VASAN-DATTA 340 31. Date filed (Month.

MO

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

cour mo

MILI

29c. License number

D18017

29d. Date signed (Month, Day, Year)

ST MAKER STOWN MD 21740

28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician APRIL Day 15, 2009 HANNAH MOORE TURNER 7:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Wilson Health Care Center MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 18, 1920 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 28 F 88 Director 578-44-7306 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MDGaithersburg Montgomery 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 W. Deer Park Road 20877 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Director TESS yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Homer Moore Sadie Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terri Sommerville (Daughter) 109 W. Deer Park Rd, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from Sta of Heaven Cem 4/21/09 Gate Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. P.nt1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onsel and Death **Physician** To caro nasu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated events resulting in death) Last Examiner law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐Yes 2☐No Month Dav Vear 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an in, Currie Anessee After this certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ☐ ER/Outpatient 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No after death 2 Accident 6 ☐ Could not he 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral I 29a, Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 04115 Well weit Dorsch 201 RUSSELL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IL ROBERT BIRSCHBALLY GALTHERSBURG, MA 20877. nes 31. Date filed (Month; Day, Year) 32 Registrar's Signature State 21 Registrar